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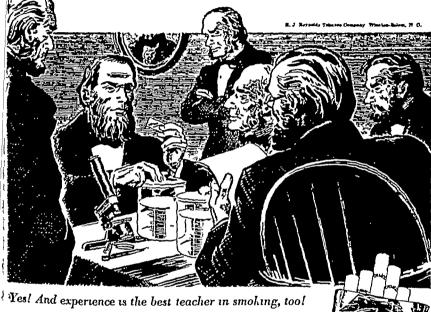
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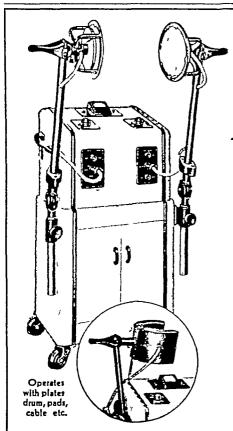
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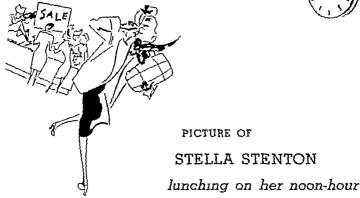
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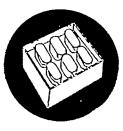
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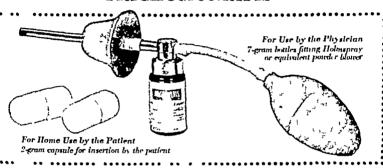


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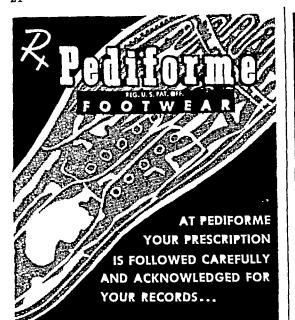
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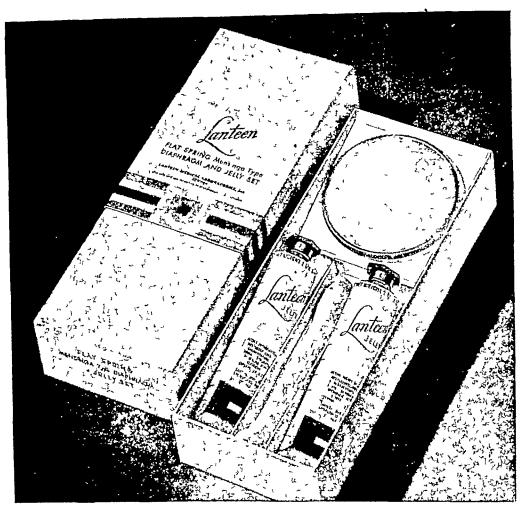


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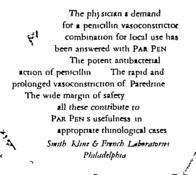
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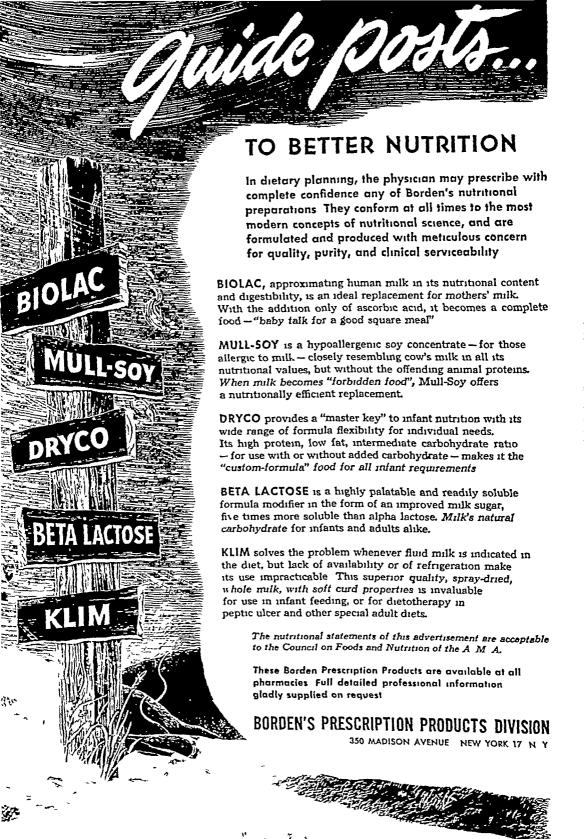
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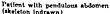
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1 F Bicknell and F Prescott, The Vitamins in Medi cine Grune & Stratton, 1946

2. M. M. Eliot and E. A. Park, Brennemann's Practice of Pediatrics, W. F. Prior Co., Inc., 36:66, 1946.

3. J B. De Lee and J. P. Greenhill, Obstetrics, W. B. Sanders, 1943

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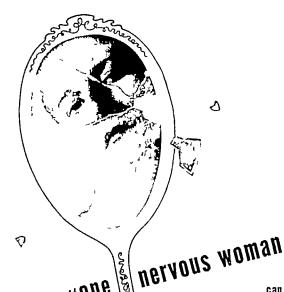
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VOLUME 48

JANUARY 1, 1948

NUMBER 1

Editorials

The Annual Meeting

The Annual Meeting of the Medical Society of the State of New York will be held at the Hotel Pennsylvania, New York City, May 17 to 21, 1948 We give these dates editorial mention at this time to call the attention of the physicians of the State to an event which will be of more than usual interest this year Mark it well, and if you can attend, write now for hotel reservations. Events will come with a rush in 1948, so use that new appointment book to jot down now the dates of May 17 to 21 Make your plans now to attend

Hotel space is difficult to obtain and is at a premium in the larger cities.

The District Branches

Part I

Once a year, usually in the Fall, the District Branches hold their meetings throughout the State of New York. Like many other accomplished facts they are too often taken for granted, their origins are lost in the dim recesses of history When were the District Branches founded? Why? Are their purposes and functions now what they were originally?

Behind the formation of the Branches less a dramatic story It begins in May, 1846, when a resolution was introduced in the National Medical Convention in New

¹ History of the American Medical Association, Saunders, 1947 p. 35.

York calling for the appointment of "a committee of seven to report a code (of medical ethics) " The committee was directed to report in 1847 at a meeting to be held in Philadelphia in May The committee fell to work and examined a great number of codes of ethics adopted by various societies in the United States. It concluded that they were all based on the code of Dr Thomas Percaval, who was graduated from Leyden in 1765 and who became a Fellow of the Royal Society of England in the same year In 1803 he published a series of ethical principles for the guidance of the conduct of the hospital

and infirmary of Manchester This code, substantially unchanged, was presented for the "committee of seven" by Dr Isaac Hays at the National Medical Convention in Philadelphia in 1847

In 1823 the New York State Medical Society had adopted a code of ethics which was "almost wholly similar to the code prepared by Thomas Percival" Thus both the code of ethics of the New York State Medical Society and that of the American Medical Association derived from the same source but at different times

At the annual meeting of the New York State Medical Society in 1881² a committee was appointed which drew up a new code of ethics "to be substituted for the one then in force" It was adopted in February, 1882, but met with "considerable opposition from many of the County Societies"

In June, 1882, the American Medical Association at its annual meeting in St Paul refused to accept the credentials of the delegates from the Medical Society of the State of New York, or to admit them to its proceedings because of the adoption of the revised code Now the fat was in the fire, and began to burn brightly The curious anomaly arose that the State of New York which, in 1847, had been the moving spirit in the formation of the American Medical Association was excluded from the proceedings of the very society it had created The backfire was sudden and caused a rupture in formal relations2 that endured for nearly a quarter of a century

In the State of New York the medical profession, in 1883 at the time of the annual meeting of the State Society, was in more or less turmoil The national or "old code" had been supplanted by the "new code" Now a resolution was offered at the annual meeting in 1883 "which was meant to take the place of the formal code of adopted in the previous year This resolution was carried." In effect it stated that "the only ethical offences for which the profession of New York claim and promise to exercise the right of discipline are those comprehended under the commission of acts unworthy a physician and a gentleman" The Medical Society of the State of New York thus formally became a "no code" organization 2

A poll of professional opinion was taken and it was found that

- 2,547 physicians wanted the national code
- 1,040 physicians wanted the new code 239 physicians wanted no code 34 physicians were unclassified

As a result of this canvass a new society, the New York State Medical Association. was organized in 1884

The District Branches

Part II

Under the energetic guidance of Dr Austin Flint and other supporters of the national code, a preliminary convention to form the New York State Medical Association was called, February 4 and 6, 1884, in the City of Albany 1 Omitting the debate, now inconsequential, which preceded the resolution offered by Dr Gouley relating to a plan of organization,2 we find that the first item in this plan was one to facilitate the transaction of business Dr Gouley

t Trans New York State Medical Ass n 1.504 (1884)

* Ibid p 528.

proposed that "the State shall be divided into five geographical districts, to be called, respectively, the 1st, or Northern District, the 2nd, or Eastern District, the 3rd, or Central District, the 4th, or Western District, and the 5th, or Southern District

"These districts shall comprise the sixty counties of the State " Dr Gouley's resolution was unanimously carried

Here then for the first time appear the five Districts, formed "to facilitate the

² History of the Medical Society of the State of New York T J Walsh 1907 p 204 ² Trans State Soc 1883 p 78

² Note that in 1884 Nassau County was not yet for

selection of committees, the annual election of officers and of new members" Other significant items contained in the resolution were "The code of ethics, which shall form an integral part of the by-laws of this Association shall be the same as that adopted by the American Medical Association"

The New York State Medical Association was incorporated under Chapter 207 of the Laws of 1875, May 3, 1884 A plan of organization of five branches of the Association was presented and adopted November 18, 1884 The already established County Societies were affiliated with and were component parts of the Medical Society of the State of New York This fact posed a serious question Would it be necessary to create new County Associations? Preponderance of opinion seemed to be that it would not, those County Societies that adhered to the national code could be considered as in affiliation in fact if not by statute with the State Association creation of the Branch Associations would afford organizations "that could conveniently be attended by physicians throughout the State " County Societies were "too small for pleasant and useful work." The case was different with respect to District Branches, each branch covered an area of from 10 to 14 counties, and the attendance at these meetings was sufficiently large to favor better scientific papers and discussion

It is difficult for the doctor of today to consider his medical organizations to have been other than they are now It is true that fundamentally all the doctors' organizational work has had the objective of the promotion of better medical education, better ethical concepts of the relation of the physicians to other physicians and to the public, the provision of better public health and the advancement of the science and art of medicine In the nineteenth century the attitude of the regular profession toward the downright quacks, and the irregulars (homeopaths and eclectics) was in the main uncompromisingly hostile But it appears from the Transactions of the State Medical Association that control of the other Society (The Medical Society of the State of New

York) had been captured prior to 1884 by certain elements in New York County and similar groups in other County Societies who were not supporters of the national code of ethics, who were, on the contrary, proponents of the "new code" of 1882, and included some who favored "no code". These gentlemen were not averse to consultation with "irregulars," a practice not permitted by the national (or Thomas Percival) code of the A.M.A.

It will be noted that, in 1883, the poll of physicians in New York State who wanted the national code was 2,547. This number represented the potential strength of the new Association, but even so "it was realized that with the constitution of the State Medical Society as it then was and with the membership as determined by it, it would be practically impossible to obtain any legislation of such a nature as would bring about a reunion with the national body"?

The five branches of the new State Medical Association created in 1884 were the beginnings of the present-day District Branches.

There had been districts previously established Examination of the Transactions of the Medical Society of the State of New York's shows that "The Society then (1808) proceeded to arrange its members into four classes, according to the four great senatorial districts of the State" Thus the original State Medical Society did have, in 1808, a somewhat similar district arrangement. These districts were Middle, Western, Eastern, and Southern Note, however, that the number was four

In 1884, the seceding State Medical Association did not have the County Societies as components. These had been established by statute as components of the Medical Society of the State of New York in 1807 And the Medical Society of the State of New York with its component County Societies was the official organization of the medical profession of the State at all times

Thus the five Branch Associations of the

Trans. N Y State Med., 1:1885 (1884)
 Tbid.: p. 598.

Out of a total of 3,860 queried, 7 Hist, Mad. Soc. State of New York, J. J. Walsh, 1907 p. 206.

p. 206.

Second Meeting, Albany First Tuesday of February 1808. See Transactions for detailed account.

seceding New York State Medical Association were of the utmost importance to the new organization for administrative purposes

(To be Continued)

Developments in Health Legislation

According to a brochure published by the Research Council for Economic Security, study of the legislative record of 1947 shows "increasing interest in the establishment of compulsory health insurance systems and expansion of governmental health services"

Congressional legislative activity in the field of health apparently "tends to emphasize health services, either through a national compulsory health insurance system or through grants to states"

On the other hand, most state bills call for cash sickness benefits None of the bills in 1947, either State or Federal, became law

The Research Council comments on the importance of the increase in the number of bills, seeing therein a developing trend Says the brochure "In 1935–1936, ten bills were introduced in state legislatures, in 1945, there were thirty-nine bills, in 1947, there were fifty"

These fifty odd bills were introduced in sixteen state legislatures "calling for the establishment of compulsory systems of sickness benefits or health insurance"

The legislative proposals are broken down into six classes (1) Cash Sick Benefits—Monopolistic Type, (2) Cash Sick Benefits—Optional Type, (3) Cash Sick Benefits—Voluntary Type, (4) Unemployment Sickness Benefits, (5) Prepayment Medical Care, (6) Pregnancy Benefits

Important is the numerical breakdown of the six classes Of the fifty odd bills, twentyfive, or fifty per cent, fall into Class I In this type, benefits and coverage are "identical with unemployment compensation, and are to be financed by payroll taxes levied on workers and/or employers, varying from 1 to 2 per cent of payroll A monopolistic state is to be created for the payment of fund benefits, affiliation is compulsory, and there is no provision for alternative voluntary Of this class of bill, eleven plans were introduced into the legislature of the State of New York in 1947, and three in New Jersey and Massachusetts, respectively One each was introduced in Pennsylvania, Nevada, Minnesota, Maryland, Illinois, Connecticut, Arizona, and Alabama monopolistic state fund in this class of bill was modeled after the Rhode Island plan

At the commencement of a new legislative year, such a study is of much value. Is the trend of the past ten years likely to continue? Will the coincidence of an election year accelerate the activity? The report of the Research Council points out that failure of current bills to pass "does not mean that demands for this type of legislation is on the wane"

We have omitted detailed comment on the five classes of state legislation other than to list them. It appears obvious that in the State of New York, with eleven bills of the monopolistic type in 1947, six bills in class IV, one in class V, and two in class VI, the spread is wide with a slight emphasis on the monopolistic type of cash benefit. The value of such a survey to the medical profession seems to be to show the trend of thinking on the part of those proposing the legislation. A further report for 1948 will be awaited with much interest.

Current Editorial Comment

G P'S to Get the Works The coming four-day session of which an indication is given below should work out as an endur-

ance test, however much or little it may succeed as a postgraduate educational project

¹ Health Legislative Developments 1947 Research Council for Economic Security 105 W Monroe St. Chicago, Ill publication No 53

In addition to technical and scientific exhibits, a program designed particularly as postgraduate education for general practitioners will be presented at the supplemental session of the American Medical Association in Cleveland, Ohio, January 5-9, 1948.

The Council on Scientific Assembly, whose chairman is Dr Henry R. Viets of Boston, has prepared a program which will include papers. panel discussions, and symposia on many of the topics now most prominently before mem Among the bers of the medical profession topics to be covered are peptic ulcer, blood dyscrasias (any abnormal composition of the blood), the chronic invalid, nosthospital care of patients with cancer, treatment of the fat and the lean, cancer of the prostate, the use of BCG (Bacillus Calmette Guérin) vaccine in the prevention of tuberculosis, uterine hemorrhage, multiple injuries in automobile accidents, the treatment of pathologic conditions in adolescence, the treatment of the healthy and sick diabetic patient, jaundice, the Rh factor, and the interpretation of x ray films of the chest

During the first two days of the session the Council on Industrial Health of the American Medical Association will conduct a program devoted particularly to problems in its field

Planned for the Scientific Exhibit is a demon stration of the operation of a diagnostic cancer clime, in which visiting physicians will be given the opportunity to undergo themserves the routine of such an examination

We believe that the last-named feature, the demonstration of the operation of a diagnostic cancer clinic, should prove to be of great value One picture is better than a thousand words Dr Viets has outlined a most valuable program

Longovity of American Physicians

The expectation of life for physicians in the United States is essentially the same as that for the general white population at the same ages, according to a study by the Metropolitan Life Insurance Company based upon the records of deaths among active and retired physicians in the files of the American Medical Association The study covered the five-year period 1938 to 1942, inclusive. The average male physician entering his profession at age 25 has 43½ years of life before him. This represents roughly the average professional career of a physician under current conditions of mortality Upon reaching age 35, he still has, on the average, almost as many

years remaining as he has already lived. At age 45, the average physician may expect to live an additional quarter century, and at 65 often regarded as retirement age, he may still look forward to almost 12 years of life Women physicians start out with an advantage of 3½ years over the men at age 25, but this margin is reduced to less than 1½ years by age 65

The death rates for the physicians and the general population are practically identical at ages 75 and over

Those physicians who survive into late life, where they experience about the same mortality as the general population are presumably the hardier individuals, who may be benefiting from the advantages of an especially good heredity or a favorable environment, or both.

It would seem that the first hundred years remain, as we surmised, the hardest, for physicians as well as for barkeeps, plumbers, pretzel benders and/or farmers

¹ Statistical Bulletin, Metropolitan Life Insurance Co. (Aug.) 1947 p. 1

Health Instruction Necessary in the Schools. No one can say what is in store for this nation in the years to come The President of the American Medical Association recognized the fact, however, that, whatever is to come, the national health must be improved through health education in the schools

"If health is the nation's most valuable asset then it should be a number one topic for instruction in the schools," Edward L. Bortz M D., president of the American Medical Association, said in a speech prepared for delivery before the Conference on the Cooperation of the Physician in the School Health and Physical Education Program at the Hotel Moraine, Highland Park, Illinois, October 16, 1947

According to Dr Borts, the schools and organ ised medicine have been the objects of much unfair criticism because of the high proportion of young men found unfit for military service by Selective Service in World War II He pointed out that those who enlisted voluntarily in the first two years of the war and the others who were deferred because of essential occupation or dependency were not examined under Selective Service. Furthermore, only 19 per cent of the rejections were for conditions really preventable or correctable.

Nevertheless, Dr Bortz observed "It must be admitted that some stimulation is necessary in certain portions of the country to modernize the health and physical education program in all grades of the school, if the youth of the land are to make a better showing in the event of a third national challenge. He said that "in a large measure a modern educational program should include many of the activities which our great military leaders hope to accomplish through a program of compulsory training

"Basic facts concerning the rules of health should be included throughout the entire extent of the school curriculum," the AMA head "Good habits in regard to nutrition, remarked elimination, rest, and recreation should be developed in youngsters in their most impressionable years in the home, and the school curriculum atmosphere and extracurricular activities should solidly reinforce these early teachings, particularly providing full and scientifically accurate Concomitantly, physical health information examinations should be made at regular intervals. if not by the family physican then by the physician serving the school School physicians with the close cooperation of teachers have an unexcelled opportunity for instruction in the basic facts of healthful living as school children are being checked over for incipient defects, disease. or other short-comings Unhealthy emotional states, bad teeth, malnutration, muddy skin, constipation, and a number of other common discrepancies are usually quite readily identified Correction is not always as easily accomplished. but the physician can often point the way and create the desire to follow it

"A most wholesome sign," Dr Bortz continucd, "is the friendly cooperation between educational leaders and health authorities from the medical profession A modern health program for the schools of the various communities is an excellent subject for discussion with parentteacher associations, civic clubs, church groups. and various other auxiliaries and societies Such discussions, forums, and question and answer periods are excellent media for distributing significant information not only to members of the school population, but to others participating in the programs A school health program such as we visualize can best be worked out at the community level It will more likely succeed if encouragement descends from the state and national educational centers where policies are determined, and subjects for inclusion in the curriculum are selected

"Let us have a more healthy nation Let us get together on a plan of action that will clearly show youngsters and their parents that it is in their best interests that certain basic rules of health should become part of their daily living program. An enlightened public does not require compulsion and regimentation.

"A clarification of our national needs, supported by a modern program of instruction in health and the democratic way of life, is the surest guarantee for the nation's security. The development of such a program, to my mind, is the most important educational task which is facing our nation today."

Are Trimmings Necessary? In speaking of the necessity for every doctor practicing every kind of medicine to be constantly cognizant of the psychosomatic aspects of his patients, Dr 'Walter C Alvarez' says, "Our advice must always be practical, in other words, we must not tell the widowed scrub woman with five children to take a vacation in Florida Our speech must also be simple and colloquial"

The French have a word for it—"L'esprit de l'escalier" Freely translated, it means the bright remark you wish you'd made when engaged in flashing repartee with the guest of honor at the party, but which actually only comes to you after you have been left tongue-tied in the emergency and are shame-facedly descending the stairs that lead you to the drab home from which the suitably timed remark might have rescued you

Broadly speaking, there are two types of Those who, when Christmas approaches, take bands of children from the slums and escort them through the glittering marvels of the town's most modern toy store There the undernourished waifs see electric trains, meccano sets, French talking dolls, aluminum skis and other modern marvels too numerous to mention of the children had never dreamed of the existence of these anodynes for the relief of jaded childhood, but, when they have seen them, there is just one thing of which they may rest completely certain—that they will not personally possess any of them

The second type of person does not take poor children to the toy store the week before Christmas

These reflections cast a little light upon the problem of a patient which had recently baffled us

A happily married—so she said—woman of thirty-nine was childless. She had a happy family background, was happy in her job, and was of rather more than average intelligence. Seven years ago she suffered a bizarre but not very severe accident which caused her to be subjected to a spinal opera-

¹ Alvarez Walter C J.A.M.A 135 704 (November 15)

tion The operation had been successful in relieving her disabling pain, but in spite of the success of the operation she had since been, in her own words, "good for nothing" Hours of patient questioning revealed that before the operation her greatest pleasure, in her rare times off, had been to go "window shopping" Now she no longer had the

strength even for that It suddenly occurred to us that she might have graduated from the first class of people that we have just mentioned into the second Perhaps her subconscious mind had more sense than she had Perhaps it had told her that she and her husband between them, or together, would never be able to possess the beautiful things that, after the day's work was over, she dragged her weary limbs to see Perhaps it told her common sense indicated that she stay at home rather than waste her strength and deplete her morale by constant contemplation of the unattainable "L'esprit de l'escalier" almost made us call her back

We think our diagnosis very likely is correct, but to make any treatment effective what must we do? We must teach our patient to fling away ambition We must teach her that she and her husband are only average people She must abandon the vision of herself tripping into swank restaurants swathed in the latest thing in mink or sables We must strip every bit of gilt from her meager allowance of gingerbread We don't know whether we could do it if we tried. And we are not at all sure that we, on mature consideration, life being what it is, would wish to try

We yield to no one in our recognition of the necessity for the universal practice of psychosomatic medicine But we think it will do no harm to point out that the best intentioned of practitioners who tries to practice it may often find he has bitten off more than he can chew

Still, what is man's reach for, if not to exceed his grasp?

New A.M.A. Public Relations Counsel. Dr George F Lull, secretary and general manager of the American Medical Association, announced recently the appointment of Lawrence W Rember as his executive assistant in charge of public relations

Mr Rember, who fills a post vacated by the resignation last June of Charles M Swart, assumed his new duties on December 16 At the same time, Dr Lull announced the appointment of the Chicago firm of Theodore R Sills and Company as public relations counsel for the American Medical Association

Mr Rember gained his experience in the health and public service fields as director of public relations for the Blue Cross Plan Commission of the American Hospital Association and as public relations director of the midwestern area of 17 states of the American National Red Cross

Mr Rember has served as assistant general manager of the public relations nutrition research agency of the poultry and egg industry, representing 28 national and regional trade associations. He received his master's degree from the Medill School of Journalism at Northwestern University and his Bachelor of Arts degree from the University of Wisconsin, where he special ized in journalism and commerce. He supplemented this education by teaching journalism and advertising at the Henry W Grady School of Journalism, University of

A member of the National Association of Public Relations Counsel and a director of its Chicago Chapter, Mr Rember is also secretary treasurer of the association and writer of its official publication

It is hoped that the doctors of the United States will now be in a position to carry forward a consistent and widespread effort to bring to public understanding the real values of a free and independent medical profession. The art and science of public relations is not a matter to be conducted haphazardly. And the public relations of the medical profession should be subject to the guidance of the best counsel available.

Human nature does not change radically One remembers that Martial wrote, undoubtedly interpreting the feeling of his time

Non amo te, Sabidi, nec possum dicere quare, Hoc tantum possum dicere, non amo te

Tom Brown interpreted this literally in his time

I do not love thee, Doctor Fell, The reason why I cannot tell, But this alone I know full well I do not love thee Doctor Fell

One may assume for purposes of argument that the good Doctor Fell was possibly some doctor of medicine who had ministered to Mr Brown during a seizure of gout Is Mr Brown stirred by emotions of

gratitude? Not noticeably "Fellow's a fool'," he probably muttered to himself between twinges Yet it may be presumed that the good Doctor Fell was doing his best for his patient, lacking evidence to the So in these modern times, with contrary many startling developments of medical science, better education of the profession, more effective methods of treatment to place in the service of ailing humanity, Dr Fell nevertheless is not wholly understood Mark you, neither in the time of Martial, nor in that of Tom Brown, nor yet today is there any specific reason stated for disgruntlement Some reasons there may be, a few there undoubtedly are, but they are not specified

Dr Fell in this day and age has much to give, much to say But he is at a disadvantage in speaking to the folks One way around that is to get someone to do it for him, someone who knows when and how Maybe some future poet may write

I still don't love thee, Doctor Fell, Because, when sick, I feel like hell, But this I know when sick or well, I have a friend in Doctor Fell

Doctor Fell is no longer just a single individual, even in his contacts with his patients. He is or should be the ambassador of hope, bringing cheerful greetings from a host of educators, research workers, hospital administrators, instructors in medicine, nurses, specialists, from all that vast army of mercy standing, if one visualizes them behind him, with one intent, one purpose, one ideal, the conquest of disease

Doctors' Help Urged in Accident Preven-In many ways doctors and health department personnel could be more effective than the police in preventing accidents, according to Edward Press, M D, a pediatrician with public health training who is regional medical director of the US Children's Bureau in Chicago in the November 29 issue of the Journal of the American Medical Association, Dr Press observes that "any problem that confronts the physician with 9,800,000 injuries severe enough to cause disability in a single year in the United States urgently demands his attention "He points out that in 1943 accidents were the leading cause of deaths in all children in the United States from one to 19 years of age

In 1944 accidents ranked fourth as a cause of death for the population as a whole,

preceded only by heart disease, cancer, and intracranial vascular episodes and still leading such notorious killers as tuberculosis, nephritis, and pneumonia

In 1945 motor vehicles caused only about one third of the accidental deaths. Almost one half of the others occurred in the home, where, the writer believes, safety hazards could be checked by visiting doctors, public health nurses, and others in similar positions much more tactfully than by members of the police department.

Besides the standard methods of promoting safety Dr Press suggests

1 Taking advantage of occasions in which a doctor's patients would be most "psychologically receptive" to safety education, i.e., when a baby is being inoculated against the various communicable diseases, or when a patient is being treated for some minor injury due to accident

2 Reporting of "accident-prone" diseases, such as epilepsy, alcoholism, or drug addiction, to the proper authorities

3 Requiring regular physical examination for drivers, including regular and stereoscopic vision, hearing, and reaction time

4 The use by civilians of identification tags which would include such items as blood group, presence of serum sensitivity, abnormal bleeding tendency and tetanus immunization

5 The registration and periodic inspection of bicycles, with the requirement of certain safety essentials

6 Treating children with unusual proclivities for accidents in psychiatric clinics

7 Integrating an accident prevention program into the structure of a local or state health department

8 More education in accident prevention technics for physicians and nurses at schools of public health

The appalling accident toll, mounting disability resulting from this cause, and overburdening of hospital facilities hampered by current nursing shortages make it seemingly imperative that physicians enter the campaign being waged by the National Safety Council and others, using the suggestions made above by Dr Press as a guide

The word "doctor" originally meant "teacher" Perhaps this aspect of the physicians' function has been neglected outside of the formal instruction given in medical schools and hospitals by medical men One can teach in the home, in the office, in casual conversation. It should be done more often

Scientific Articles

SUBSEQUENT CHILDBEARING OF PRIMIGRAVIDA PRESENTING A BREECH AT TERM

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(From the Obstetric Services of the Buffalo Children's and Buffalo General Hospitals)

WE KNOW there is universal appreciation of the fetal risk when, at the enset of labor, a primigravida s child presents by the breech. The factors that influence the incidence of this complication have been analyzed repeatedly In all probability many of us should review our concepts regarding the occurrence and management of breech presentations. If the majority of breeches were due to so unalterable a factor as a contracted pelvis, there would be little reason to weigh a higher fetal risk against preservation of the primipara's ability to bear subsequent children by normal births In 1940, and again in 1945, Vartan published observations that have awakened interest, not so much in the etiology of breech engagement, as in the factors that seem to prevent cephalic presentation 12 His work has been substantiated in this country by Tompkins, who found evidence that a relatively small pelvis rarely accounts for the occurrence of breech presentation 14 Actually, large postmature babies usually present by the vertex, and breech presentations occur relatively often with small premature infants. Vartan noted the frequency of breech presentation during the eighth month of gestation and emphasized his conviction that spontaneous conversion to a vertex will occur unless (1) labor begins prematurely before the vertex has become engaged, or (2) a fetal attitude of extension, rather than flexion interferes with the occurrence of spon taneous version during the last weeks when engagement takes place.

Certainly there is little evidence that the vertex fails to engage because of some maternal factor that will persist to influence the course of labor when the same woman's subsequent preg

nancies reach term.

Management

The fetal and maternal risks involved in delivery when the first term child presents by the

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breech have been studied repeatedly by Goethals, 3-7 Hansen, Higgins, Mohler, 10 Moore and Steptoe,11 Potter et al .12,18 Racker,14 Rucker,18 Tompkins, 4 4 Varian, 1 2 Voct et al .16 Walsh and Kuder," and Waters."

The experience and relative skill of the accoucher would seem to be a matter of paramount importance This thought has been expressed by Rucker,18 Stein,19 and Tompkins,3 4 the latter reporting a low fetal mortality when breech delivenes were conducted by a group of obstetric specialists. Hansen's report also suggests that excellent results can be obtained by conserva tive management in experienced hands ever, there are occasions when many of us would agree with the Potters, who state that increased personal experience with operative delivery does not guarantee better than average results when delivering a primigravida of a breech at term.

Authoritative oninion remains divided as to the advisability of active intervention Routine extraction under full anesthesia and not infrequent resort to elective section has been advocated by Bill.23 Goethals 4-7 Potter, 12,13 Vogt, 16 and others. However statistical comparisons of the results with varied management have been presented by Greig Moore and Steptoe, 11 and Waters, 19 all of whom, interestingly enough, conclude that conservative management gives best results in uncomplicated breech delivery. In most instances, after spontaneous delivery to the umbilious has been accomplished, unless disproportion, intrapartum bleeding, or a prolapsed cord appears, the conservative school recommends interference only to assist delivery of the shoulders and head Such management has been recommended by DeLee, 24 Hansen, Higgins, 9 Mohler,14 Nicholson,25 Schumann 25 and Tompking.

Conversion of the breech to a cephalic presentation by external version has been recommended by Higgins Slegel, 21 and McNally procedure recently has been evaluated by Rucker and Vartan but is generally, and probably rightly regarded as of very limited value.

We hesitate to believe the increased fetal risk indicates section, except when circumstances seem to justify the maternal risk involved While the maternal mortality in cesarean section is now generally low (it should not be more than 1 per cent), the figure ten maternal deaths in 1,000 sections, when compared to the New York State average approximating ten maternal deaths per 10,000 deliveries, reveals the operation as a tenfold greater risk to the mother as important to remember as the immediate operative risk, section leaves the woman predisposed to serious obstetric accidents in subsequent pregnancies Duckering recently reviewed the risks to both mother and fetus of delivery when the uterus contains the scar of a previous section 22 Obviously before electing a cesarean we should remember that the operation carries a tenfold greater maternal risk than vaginal delivery and that there are potentialities for trouble during subsequent pregnancies whenever we place a section scar in the uterus

All observers report a significant incidence of macerated or very premature nonviable infants born to a primigravida presenting a breech at the onset of labor It must be remembered that employment of elective section could not change either figure appreciably Moreover, an additional number of babies are viable but premature to a degree that makes dystocia an unlikely factor as far as the fetal risk is concerned Before the gestation reaches term, section would not be indicated unless premature labor began, and it is our belief that when premature labor begins section is not warranted. At term, when the baby seems large and dystocia might be anticipated, section should be considered In an obviously correctly selected group of cases, Potter has reported no fetal deaths among 80 consecutive sections when the indication for operation was the presentation of a breech by a primigravida at term On the other hand, it is evident that the routine employment of cesareans would not avoid fetal losses from prematurity or the antepartum causes of fetal death

We feel a decision in regard to the best method of handling the individual case should not be based merely upon knowledge of the fetal risks involved if vaginal delivery is elected. The eventual consequences of the type of delivery chosen upon the mother's subsequent child-bearing should also be taken into account. Long range considerations must be weighed if one contemplates operative intervention with its greater chance of maternal trauma, and is particularly to be considered when elective section is contemplated.

Material

This study was undertaken in the hope of gaining knowledge of the behavior during subsequent deliveries that could be anticipated, if the primigravida delivering a breech at term were so managed as to safeguard primarily her ability to carry subsequent children to term and bear them through normal labor No effort has been made to contemplate the subsequent fertality of women presenting their first child by the A shifting population and our mability to learn whether stenlity was voluntary or not seemed insurmountable difficulties if a significant number of patients were to be considered The cases selected have been chosen simply because in this number alone, reliable information concerning their subsequent obstetric history could be obtained

Our conclusions are based on a study of the records of women delivering in the Buffalo General and/or the Buffalo Children's Hospitals during the years 1937 to 1946, inclusive One hundred and seventy-nine histories proved adequate for analysis among the records of 898 breech deliveries occurring during this ten-year period, when a total of 23,241 women were delivered in the two institutions. While the number of patients considered is not large, we know of no reason why they should not represent a reliable reflection of the behavior that could be expected among the population at large.

Observations—The obstetric histories of 179 women whose first child at term presented by the breech have been reviewed. Seventy-six and five-tenths per cent of these patients were less than 30 years of age when delivered as primipara, and 8 8 per cent were 35 or more years of age. This is a rather high incidence of elderly primipara, considering that Walsh and Kuder¹⁷ reported only 2.74 per cent primiparas over 35 years of age among 29,683 deliveries occurring at the New York Hospital between September 1, 1932, and May 31, 1943.

Maternal Mortality —There were no maternal deaths, when the 179 women delivered breeches as primiparas, or during the subsequent deliveres since observed among this same group of women Only one of the 179, an "elderly primipara," was delivered by cesarean section. This same patient, delivered by section when her second child was born, was the only multipara sectioned.

Fetal Mortality—Considering the fetal risk involved in the vaginal delivery of a breech, it seems logical to omit fetal losses when labor terminates in the delivery of a nonviable child (weighing less than 1,500 Gm) or a macerated fetus. All neonatal deaths and all stillborns,

except those born macerated have been con sidered in calculating our fetal mortality rate. only the nonviable and macerated have been excluded in the thus "corrected" fetal mortality

Fital Mortality (as Principara) - Among the primigravidas under 30 years of age, the corrected fetal mortality was S 1 per cent, and among those over 35 years of age it was 83 per cent

There were 17 deaths among the viable infants born when these 179 primiparas were delivered of a term child presenting as a breech, a corrected fetal mortality rate of 89 per cent Another 10 7 per cent of infants were nonviable, macerated, or neonatal deaths, which accounts for the fact that only 144 of the 170 women (80 4 per cent) gave birth to normal babies that left the hospital with their mothers. For comparison, among 2,834 consecutive deliveries of primiparus (including all types of presentation and complications) at the Buffalo General Hospital, 92 9 per cent gave birth to a fetus that survived These figures are in agreement with many previously reported and suggest that the primigravida presenting a breech at term has four chances in five of taking home a normal childa figure acknowledging a fetal risk approximately three times the average loss among firstborn (Table 1)

TABLE 1 — Fetal Mortality Among 170 Women De livering a Breech as a Primpara Plus a Subsequent Delivery at Tray

Yumber of Patients Reported	Number of Breech Deliveries	ery Record as F Fetal Mortality (Corrected)	Total Babics Burylving
179	179	8 907	60 4% (average for BOH primipera— 92 9%)
	Deliv	ery Record as A Over-all	
	Presentation	Fetal Mortality (Corrected)	Total Babies Surviving
	Vertex, 141 (78 8%) Recurrent breech 38 (21 2%)	3 9%	88 5% (average for BGH multipara— 93 2%)

Fetal Mortality (as Multipara) -There were seven deaths among the viable infants born when these 179 women delivered their second child, for a corrected fetal mortality rate of 39 per cent. This is significantly higher than the 24 per cent fetal mortality average for all types of delivery in the Buffalo General Hospital during the years 1037 to 1946 However, among the 141 women who delivered their second child as a vertex, the fetal mortality was 2 13 per cent, suggesting that no maternal factor predisposing to more than average difficulty was present in the majority of cases

The incidence of nonviable infants was somewhat less than when these 179 women had de-

livered as primiparas, and 88 5 per cent of the group gave birth to a normal child that survived This compares fairly well with the average noted at the Buffalo General Hospital during the years 1937 to 1946 where, among 3 387 multiparas, 93.2 per cent gave birth to a child that left the Hospital alive

Although the small number of cases detracts from the apparent significance it is at least an interesting observation to note that the women who lost a viable baby as a primipara expenenced better fortune as a multipara One of the 17 had a nonviable premature child, of the remaining 16, all gave birth to babics that sur

TABLE 2 .- FETAL MORTALITY AMONG 179 MULTIPARAS

AFTER DELIVERY OF A BREECH AS PRINIPARA AT TERM			
	-Subsequent Delivery of a Vertex-		
Number of Patients Reported Number		Fetal Mortality (Corrected)	
1 9	141 (78 871)	2 13%	
	-Subsequent Delivery current Breech		
	Number 38 (21, 2%)	Fetal Mortality (Corrected) 10 5%	
	38 (21 2.4)	10 0%	

Recurrent Breeches -It is interesting to note that when these 170 women came in for delivery of their second baby in 38 instances (21.2 per cent) the breech presentation had recurred (Table In this group the majority of fetal deaths occurred and the corrected fetal mortality rate was 10 5 per cent for delivery of breeches among this small series of multiparas. Four of these 38 women whose second child also presented by the breech had lost a viable first child, but fortunately none of the women, presenting a recurrent breech, lost both their first and second ahıld

Here again our series is too small to warrant conclusions regarding the management of com plications, but analysis of fetal losses suggests that accidents of pregnancy probably unrelated to the breech presentation often account for a fetal death. In this category we can hardly include prolapse of the cord since the occurrence of this complication might well be anticipated whenever a footling breech presents

Admittedly limited as this survey has been, it. nevertheless, suggests that with recurrence of a breech presentation difficulty should be antici-Certainly, it appears that the fetal

mortality incident to delivery of a breech is almost equally high among multiparas and primi paras. At least we would emphasize that the complications of pregnancy and labor which frequently prove fatal to the fetus occur as often

with breech presentation in the multiparas as among primiparas If section is justified to assure a live baby for the primigravida, it should be remembered that breech presentation in the multipara presents us with essentially the same problem. Induction of premature labor when the child presents as a frank breech, or elective section when disproportion or a footling breech presents, are recommended procedures that should be considered in each instance. We believe the employment of such measures in properly selected cases would save more lives than the routine employment of any procedure for all breech presentations.

Summary

The recent literature suggests that breech presentation is, in the majority of instances, due to factors existent within a particular pregnancy

Since breech presentation in the first gestation is but rarely due to maternal factors that persist in subsequent pregnancies, no more than an average number of obstetric complications should be anticipated when such subsequent pregnancies are delivered at term.

The ments of conservative handling often have been evidenced in comparative statistics, yet the relatively high fetal mortality frequently tempts us to subject the mother to greater risks in the hope of securing for her a healthy, normal child

Observation of 179 primigravidas during their delivery of an initial breech, and their record during subsequent deliveries as multiparas, seems to warrant the conclusion that the woman's subsequent childbearing should be considered of paramount importance when choosing a method for the delivery of her first child

Conclusions

In the majority of instances successful vaginal delivery of the primigravida presenting a breech at term should be expected of the obstetric specialist

Since breech presentation involves essentially the same fetal risks for the multipara as for the primipara, elective cesarean section seems indicated only in the following instances (a) when the primigravida presenting a breech is at an age unlikely to bear subsequent children, or (b) when there is evidence of disproportion that would be expected to jeopardize her subsequent delivery of any child at term

216 SUMMER STREET

Discussion

Milton G Potter M D, Buffalo—As a theoretical thesis, this paper starts out well but falls apart as it goes along. The advocated policy of management of primiparous breeches is not supported by the results obtained with its use.

In fact there is something wrong with a policy,

in such cases, which carries a corrected fetal mortality of nearly 9 per cent, and that in subsequent trials when the patients were multiparous the results were even worse (ten and five-tenths per cent corrected fetal mortality for breeches in second pregnancy) It also seems unjustifiable to sacrifice a baby's life for no other reason than to avoid a cesarean

I cannot agree with the author's statement that "in the most skilled hands cesarean section increases the immediate maternal mortality tenfold"

In our service we had two deaths in the last 500 cesarean cases and at the Millard Fillmore Hospital there has been no maternal mortility in the last 500 cesarean sections. During the years 1930 through 1946 at this same hospital there were more maternal deaths from vaginal deliveries of breech cases than from cesareans done for this same obstetric complication.

At the Polyclime Hospital in New York the maternal mortality following all causes was 12 per 1,000 and the maternal mortality following cesarean was 13 per 1,000—almost the same, rather than ten times as great. A normal, well woman may have as many babies by cesarean as she wishes. It is not uncommon today for a woman to have five or six cesareans. However, with our improved technic of uterine closure, it is not unusual to follow a cesarean done for placenta previa or an unfavorable breech, by vaginal deliveries with no maternal mortality. The dictum of "once a cesarean always a cesarean" does not hold good today.

No one should advocate routine cesarean sections for all primiparous breeches. As a practical point it would seem feasible to classify all breeches into favorable and unfavorable groups. Put all the factors present under one or the other of these two headings with emphasis on x-ray findings of the head and arms, also the attitude and location of the breech and the condition of the lower uterine segment and if the unfavorable group is topheavy, do a cesarean. Of course, judgment, based on intelligence, experience, and skill, is paramount in making a correct decision.

As Dr Bill, of Cleveland, emphasizes, it is not the bony pelvis, as a rule, which causes the trouble in vaginal deliveries of breeches but the resistant soft parts and the lower uterine segment. He stresses the need of making the way clear for the passage of the baby all the way from the lower uterine segment down through the vaginal outlet. One cannot take for granted that there is complete dilatation of the cervix just because the breech has passed through the external os and is protruding through the vulva. Making sure the cervix is wide open is essential for a successful vaginal delivery, and if there is a reasonable doubt that the head will go through, a cesarean should be done. Studying each case individually is of paramount importance.

Certainly no obstetrician is going to cesareanize any woman whose baby is small and premature regardless of presentation, but if borderline cases present themselves and if the x-ray of the head and arms indicate abnormal positions, cesarean section is in order No obstetric specialist, regardless of his ability, can successfully deliver vaginally a full term normal-sized baby whose head is unmolded and extended, and whose arms are extended lafore delivery is attempted.

The author s two indications for cesarean section are far too limited. Fifty years ago the policy advocated by the author might have been in order

but in my belief today is not tenable.

Henry S Acken, Jr , M D., Brooklyn.-Dra. Randall and Baetz present an interesting approach to the problem of treatment of breech presentation, particularly with regard to the use of cesarean section. I should like to restate their conclusions, i.e., 'elective covarean section seems indicated only (a) when the primigravida presenting a breech is at an age unlikely to bear subsequent children or (b) when there is ovidence of a degree of disproportion that would be expected to jeopardize her delivery of any child at term.

Let us examine these conclusions more closely The elderly primipara exhibiting a breech presentation at term deserves delivery by the means that will most certainly give her a living child. However cesarean section is not always necessary for this, and I would not advocate the invariable use of cesarean even under these circumstances There are instances in which an elderly primipara will have a large pelvis, a small baby a readily dilatable cervix and adequate uterine contractions to accomplish the dilatation. Let us say that the presence of a breech presentation in an elderly primipara widens the indications for cesarean section very markedly but

does not unqualifiedly demand it.

As to the second conclusion, it is hard to believe that Drs. Randall and Baets would limit the use of cesarean section in breech presentation, complicated by disproportion, so stringently as this conclusion would imply The impression one gains from reading this is that unless the polvis under considera tion is so small as to make the delivery of any child a dangerous process, then cesarcan section should not be undertaken without a test of labor actually the test of labor in breech presentation is a test of delivery, because the head comes after the baby instead of before it as in vertex presentation Such a concept disregards a present pregnancy for a possible future one, and it falls to take into conaideration the possible fetal and maternal damage caused by attempting to deliver a breech presentation through an inadequate pelvis. It would seem that this conclusion has been carried to an unwar ranted extreme The knowledge that many of these patients can, after an initial catastrophe, produce a living child in a subsequent pregnancy should have some influence on our thinking and planning in regard to breech presentation. It is quite conceivable that this fact might be of importance in the border line case and that it might here direct us toward an attempt at vaginal delivery But beyond that it should not influence us. We, as obstetricians should be expected to deliver a normal child to a normal mother To do this we must balance many risks one against another and individualize each case. We must make use of the various methods of delivery available to us and apply these methods judiciously to the individual case at hand. I do believe that we have in this paper a further factor to use in reaching a decision, but we do not have in it a rule that should be rigidly enforced

Dr Randall (closing) -I appreciate the discussion and would like to answer the criticisms First, I doubt that external version can be employed to reduce greatly the incidence of breech presentation. I am inclined to believe that Varian is right in concluding that while 20 per cent of bables may be noted to present by the breech during the seventh or eighth month of pregnancy all but 3 per cent of them will spontaneously engage by the vertex, and in the small group that thus persists, efforts at external version are usually un successful.

I do not doubt that the maternal mortality in section can be reduced to the low figure Dr. Potter reports, and I wish to congratulate him upon their record However we all know the comparative figures across the State and nation as a whole, and we believe the higher maternal mortality accompanying section should be avoided, except when there is ample justification for subjecting the mother to that

greater risk.

As for our conclusions if we knew that the breech presentation was likely to persist at term in subsequent pregnancies I believe that the primipara with a breech should be sectioned, for most reports indicate that the fetal risk is almost equally great when multiparas or primiparas are delivered of a breech at term I am afraid I falled to emphasize the main theme of this paper, i.e. realizing that the risk to the baby is greater when we attempt to deliver a breech through a borderline pelvis, since we know the same sized baby could probably be safely delivered through the same pelvis if it were presenting by the vertex. It was reassuring to me at least, to learn that when a primipara presents a breech at term, we can anticipate that when this same patient a subsequent pregnancies reach term, there is only one chance in five that the breech presentation will recur Therefore whenever the mother is young enough to make her subsequent childbearing the matter of paramount importance. we believe we are justified in electing vaginal delivery even when it implies possible loss of the first child, since recurrence of the breech presents tion is unlikely to jeopardize her delivery of subsequent children at term.

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AAPS ANNOUNCES 1948 NATIONAL ESSAY CONTEST

In collaboration with State and County medical societies, the Association of American Physicians and Surgeons is conducting its second annual national essay contest for junior and senior highschool students, both public and parochial, on the subject, "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care "

The three prize-winning essays from each county somety will compete for state awards and the best three from each state will then be submitted to AAPS for entry in the national contest Six national prizes will be awarded first, \$1,000, second, \$500, third, \$100, fourth, fifth, and sixth, \$25 cach

Medical societies are urged to appoint local essay contest committees, and to enlist the aid of auxiliaries, newspapers, schools and civic groups to gain wide student participation. The committee suggests that locally at least three cash prizes be awarded

The AAPS essay contest committee includes Dr Joseph C Bunten, Cheyenne, Wyoming, chairman, and Drs Herman C Graves, Grand Junction, Colorado, George F Grisinger, Charleston, West Virginia, Herbert T Caraway, Billings, Montana, Walter L Finton, Jackson, Michigan, C W Knudson, Seattle, Washington, and Victor Adams, Raton, New Mexico

Inquiries regarding the contest should be addressed to the chairman, AAPS Essay Contest Committee, Suite 704, 360 North Michigan Avenue, Chicago, 1, Illinois

Essay Contest Rules and Conditions

Junior and semor high-school students from all public and parochial schools located in the United States are eligible to enter the contest-except sons and daughters of physicians

Essays must be limited to 1,500 words

Essays should be written on one side of letter size paper (81/2 by 11) and, if typewritten, double spaced

Contest starts February 1, 1948, and essays must be submitted on or before April 15, 1948, to

County or local medical society or auxiliary sponsoring contest, or

State society or auxiliary sponsoring contest (b) (in the event no county or local group sponsors it), or

Association of American Physicians and Surgeons, 360 North Michigan Avenue, Chicago 1, Illinois, in the event no contest is (c) sponsored by either a county or state society

First three prize winning essays from each county or local medical society must be sent to

(a) The state medical society (if it is sponsoring a state contest) to compete for state awards,

To Association of American Physicians and (b) Surgeons, 360 North Michigan Avenue Chicago 1, Illinois, to compete for national awards (in the event no state contest is held)

First three prize winning essays from each state must be sent to the Association of American Physicians and Surgeons, 360 North Michigan Avenue, Chicago I, Illinois, to compete for national awards

7 Compositions must be original and should be well documented

JUDGING Will be solely on a basis of knowledge and grasp of the subject supported with documentation, and sound, logical conclusions
9 JUDGES

For county contests a physician, an educaand another lay person, all of whom shall have some special knowledge of the **Bubject**

(b) For state contests a physician, an educator and another lay person, all of whom shall have some special knowledge of the subject.

(c) National contest a physician, an educator and another lay person, all of whom shall have some special knowledge of the subject

(Last year's national judges were Dr Warren L Furey, President, Chicago Medical Society, Dr Herman Wells, President, Indiana University, and the Honorable Carl B Rix, President, American Bar Association)

PUERPERAL HEMORRHAGE

Is the Present Mortality Rate Unnecessarily High?

JAMES KNIGHT OUIGLEY, M.D. F.A.C.S. Rochester, New York

(From the Services of the Rochester General Hospital)

URING the past fifteen years the maternal mortality rate in this state has declined to about one third that of 1932 This lessening of the risk of childbearing has been general throughout the United States and has exceeded the fondest hopes of those largely responsible for this improvement public health officials, teachers, and practicing obstetricians, all of whom have given much thought and time to the problem.

The three major causes of maternal deaths are sepsis, toxemia, and hemorrhage. All to a great degree are preventable. The first of these to decline was toxemin eclampsia is so rare today that interns may finish a year of residence in many hospitals without having observed a case This improvement came about as a result of early efforts in maternal welfare which at that time stressed prenatal care. Better teaching and increased hospitalization of the parturient, making possible better care at delivery, combined with the use of chemotherapy and antibiotics, has reduced markedly puerperal sepsis.

To many students of the problem of maternal health it has seemed that the third great cause of maternal deaths, puerperal hemorrhage, has not shown the improvement it should and that the death rate today is susceptible of reduction Puerperal hemorrhage may be classified as due to abruptio placentae or accidental hemorrhage, placenta previa, and postpartum hemorrhage. Deaths from the two causes of antenatal bleeding are not preventable to the same degree as is postpartum hemorrhage but the determining factor in the demise of many cases of placenta previa and in some of abruptio placentae is postpartum hemorrhage.

The improvement in the mortality rate of both abruptio placentae and placenta previa is due to the increased facilities for transfusion and a better understanding of the indications for treatment, such as the performance of cesarean section in placente previa in all but the marginal variety

While the rate for both abruptio placentae and placenta previa has declined, that for postpartum hamorrhage has increased viction of the writer that the number of deaths from hemorrhage, particularly the postpartum vanety can be reduced is the result of observations made during fifteen years analysis of ma-

Presented at the 141st Annual Meeting of the Medical Society at the State of New York, Buffalo, Section on Ob-stetrics and Gyncoology May 7 1947

ternal deaths occurring in a community of over 400,000, which was well-supplied with physicians and had adequate hospital facilities.

A report of the first twelve years of this study was published in 1946.1 This included 232 deaths and the over-all picture was encouraging, for it showed a general decline from 4.5 per 1,000 in 1933 to 0 6 per 1,000 in 1944. For purposes of comparison this survey was divided into two periods, the first of five years at the time of an interim report, and the second of seven years. There were 28 deaths ascribed to hemorrhage in the twelve years. These did not include 15 deaths from ectopic pregnancy, five from ruptured uterus, and four from inversion of the uterus, in all of which categories, hemorrhage if not the sole factor, was at least the chief contributory cause. All the deaths from abruptio placentae and four of the six deaths from placenta previa occurred during the first five years, showing a substantial reduction in deaths from antenatal hemorrhage Fatalities from postpartum hemorrhage, however, increased from 5.2 per cent of the total deaths in 1933 to 1937 to 8.1 per cent in 1938 to 1944

While the issue is not perfectly clear, due to overlapping or multiple causes of death in the same case, it is undoubtedly true that mortality from puerperal hemorrhage, particularly the postpartum variety, has not shown any improvement in five or more years. One might conclude that we had reached an irreducible minimum were it not for the fact that close examination of the records of many of these deaths shows that the treatment accorded these patients in many in stances was far from ideal or from what should be expected today. The following abstracts of 3 case histories are illustrative of this statement

Case 1 -A 22-year-old para II delivered spontane-Cass 1—A 23-year-out part 11 ucuverous spinisture outs! The placents was expressed ten minutes later and was followed by considerable bleeding. The patient went into shock one hour later Vaginat tamponade was done, glucose and saline were given intravenously, nine hours later there was bleeding than the realizer that multi-star most 150 and through the packing the pulse rate rose to 150, and she died six hours later or seventeen hours after delivery There was no typing and no transfusion.
The vapina was packed but the uterus was not
Case S.—A primipars aged 23 after a long labor
was delivered with some difficulty by middorceps

operation. As there was no scrubbod assistant, the resuscitation of the baby was done by the physician. The fundus was not watched. Five minutes after the birth of the baby the lower pole of the

Conclusion

There is agreement among those who have studied carefully many fatalities from puerperal hemorrhage that a large percentage of these might have been prevented had the attendant used the knowledge and facilities available today in hospital deliveries, and had he been alert and prompt in meeting this serious emergency. The indication for controlling hemorrhage and replacing blood loss should be a measured loss of blood and not estimated loss or signs and symptoms of hemorrhage, for these lag behind the actual blood loss and treatment after the onset of shock may be too late to be lifesaving

Rh factor determination and blood typing should be a routine procedure and blood banks should be available

26 SOUTH GOODMAN STREET

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SCIENTIFIC EXHIBITS 1948 ANNUAL MEETING

Applications for space for the scientific exhibits should be made directly to Chairman of Subcommittee on Scientific Exhibits of the Convention Committee

Dr J G Fred Hiss 505 State Tower Building Syracuse 2, New York

The Annual Meeting will be held May 17 to 21, 1948, at the Hotel Pennsylvania in New York City

No Applications can be considered after January 15, 1948

There will be two groups of awards

Awards in Group I are made for exhibits of individual investigation, which are judged on the basis of originality and excellence of presentation.

Awards in Group II are made for exhibits which do not exemplify purely experimental studies and which are judged on the basis of excellence of presentation and correlation of facts

W P ANDERTON, M D, Secretary

VAGINAL HYSTERECTOMY

OLIVER N EASTMAN, M.D., FACS Burlington, Vermont

(From the University of Vermont College of Medicine)

BURLINGTON, Vermont, a comparatively small medical center in a rural state with few transients affords a rather unique opportu nity to study the merits of an operative procedure for the correction of obstatue complications and especially is this so of pathologic damages to the polvic structures. Women of preceding generations in Vermont received little or no pre- or postobstetric care Lacerations at childbirth were neglected too often because of inadequate facilities for surgical repair in the homes where 90 per cent of these women bore their bables. Two or three interrupted sutures of silkworm gut for second or third degree lacerations and no sutures for internal tears was the rule. The younger generation of gynecologists can scarcely appreciate the difficulty encountered following a forceps delivery of an obese patient in the middle of a featherbed, with the husband or a kind neighbor holding a lantern with the rays reflected as much in the physician's eyes as on the patient s peri Household duties requiring lifting and straining soon after delivery were added factors favorable to the commonly acquired "falling of the womb' Routine aid for this distressing condition called for palliative treatment with pesse nes and gadgets, hard and soft, large and small round and square, in fact, anything from an apple to a doorknob to afford relief

Retroversion of the uterus with procidentia of varying degrees, associated with cystocele and rectocele, comprises a large percentage of the cases in which vaginal hysterectomy offers a fav orable operative solution for these afflicted women. True, we have at our command other corrective surgical means which give excellent results in selected cases but considering all points, I believe no other operative procedure can offer so many favorable factors as does the vaginal hysterectomy With this thought in mind, we have endeavored to correct several of the more undesirable features of this operation and at this time submit a preliminary review of 1,000 personally operated cases in which the uterus has been removed vaginally Several years more will be required in this study to determine a number of variable factors. The operation which we now employ, and believe to be a good operation, is quite different from the one we did fifteen years At this time we are scarcely able to evalu ate the several procedures which we have used

With poor risk individuals-patients with car diac insufficiency, diabetics the obese the aged the patients with intestinal adhesion complica tions in previous abdominal operations—the va ginal approach for a hysterectomy is favored. Local anesthesia affords a minimum risk in these cases and is used routinely in the aged versely a history of previous pelvic inflammatory disease endometriosis, or any condition causing limited mobility of the uterus, with shortening of the supporting ligaments and fascia, malignancy of the cervix, adnexal pathology of any nature, or cases in which abdominal exploration is advisable. are contraindications for vaginal hysterectomy An open mind to operate whichever way is best for the patient is to be desired, and a competent gynecologist should be able to select the prefer able approach, always bearing in mind that a hysterectomy started vaginally can be completed readily from above, should conditions be found to make this expedient. Such has happened in a few of our cases. In one instance the left oversan vessels escaped from a faulty clamp and necessi tated an abdominal incision for ligation In another case a pedunculated fibroma became separated from the utenne fundus, requiring an abdominal incision to extract the tumor from coils of small intestine In approximately 25 per cent of cases the vaginal approach serves best In 25 per cent of cases this is equally true of an incusion through the ventral wall while in the remaining 50 per cent, it will make little or no difference. The choice remains for the surgeon to decide which is more convenient for him to do In our series of cases, we find we did 1,000 vaginal hysterectomies, while we did 796 hysterectomies

in determining whether or not satisfactory results are more frequently met with the present procedure than with the ones used earlier. are we quite sure which type of case lends itself best to this or that type of correction feel, however, that on general principles for the patient's best interests, certain cases can best be operated vaginally, while other cases require abdominal approach for best results Procidentia of the uterus with evstocele and rectocele is by far the chief indication for vaginal hysterectomy Metrorrhagia, near or postmenopausal, chronic cervicitis, cervical and uterine polyp fibrosis with hyperplasis and stricture of the cervix are frequently met indications. Marked clongation of the cervix and considerable procedentia following a ventral fixation of the fundus uteri is not an unumini indication

Presented by invitation at the 141st Annual Meeting of the Medical Sectory of the State of New York, Buffalo Section on Obstetries and Gynecology May 8, 1947

through an abdominal incision over the same penod

At this time it is pertinent to mention that a considerable number of vaginal operations have been performed for the removal of a cervical stump and a repair of a cystocele and rectocele where a previous operation had removed the upper part of the uterus only These cases are not counted in our study as vaginal hysterectomies I would also stress that in doing abdominal hysterectomies for several years we have left only an occasional cervix One readily appreciates why this is important after reviewing the literature with the reported frequency of stump cancer in approximately 6 per cent of well-studied cases in our leading gynecologic clinics The frequency of cervicitis, chronic infestation with trichomonas, and cystic degeneration of the cervix, play a lesser role, but are, nevertheless, important

It would be logical to assume that in vaginal hysterectomy and repair we more nearly establish normal relations of remaining pelvic tissues than in any other corrective procedure with the exception of the Spaulding-Richardson and the Incidentally, following this LaFort technic latter procedure I have encountered a relatively high percentage of recurrence of the disability for which the operation was performed, and rarely does it seem advisable to select this type of operation for procidentia The Watkins. Manchester, Fothergill, and interposition types of correcting procidentia, all seem to be based on transplanting the fundus uten to an abnormal position beneath the bladder base or anterior wall. thereby reducing the existing prolapse which constitutes an operation not aimed at re-establishing the normal relation of the tissues involved before the procidentia developed Physiologic functions in the structures involved would seem to be markedly changed I am convinced that patients who have undergone a vaginal hysterectomy are decidedly more comfortable than are those on whom I have performed one of these other operations Controversial opinion—right or wrong—the uterus still remains, correcting to a degree the prolapse of the bladder, but still presenting a fertile field for pathologic changes Restoration of cardinal fascia and uterine ligaments to near their normal level and the removal of the uterus, in which there is so frequently found pathologic changes not recognized in situ, argue favorably for total uterme removal Evaluation of existing dysfunction is highly important and should be taken into consideration in any corrective procedure In considering vaginal hysterectomy one must be conversant with the normal and be able to appreciate the necessary correction before starting the operation gree of prolapse of the uterus, of the bladder, the urethra, and the holding propensity of supporting structures, should be taken into consideration and borne in mind throughout the entire operation

Three important steps seem worth while stress-First, delivery of the fundus uten through a cul-de-sac opening permits accessibility to clamping the lateral uterine supporting structures Morcellation of the uterine body can be accomplished readily should this be required to lessen the size of the uterus in effecting its delivery Especially is this so in the presence of a large leiomyomatous uterus

Second, by inserting two fingers of the left hand behind the uterine fundus, the bladder is elevated readily so there should be no danger of incising the bladder wall when the peritoneal cavity is opened anteriorly This accident does take place in the classic vaginal hysterectomy even in the hands of competent and excellent surgeons. as several have attested I have vet to see this accident happen where the uterus is removed posteriorly

Third, a normally deep vagina requires severing the mucous membrane well down on the cervix. The approximation of the prevential columns of tissue which have thinned and separated laterally. permitting the bladder to herniate downward, leaves a long anterior vaginal wall A slightly lax anterior vaginal wall is preferable to a tense anterior wall which may give the patient discomfort when the bladder is distended Wide lateral dissection of the vaginal mucous membrane provides good bladder support, but too frequently shortens the anterior vaginal wall We prefer to maintain anterior wall depth by trussing the lower margin of the vesicocervical tissues to a high position by suturing to a central stump previously formed by the approximation of the uterine ends of the infundibulopelvic ligaments A 10 to 12 cm depth with an introitus readily admitting two fingers is desirable

Technic of Operation

With the bladder empty and the vaginal mucous membrane prepared by painting with phemerol or merthiolate solution, the cervix is grasped with 2 volsellum forceps closing the cervical A circular incision is carried around the cervix, attached cervical tissues are separated with seissor dissection and gauze over the thumb, pushing the mucous membrane upward, and exposing the lateral cervical tissues which are sutured on either side with chromic Number 1 catgut cervical branch of the uterine artery is severed below and parallel to the suture, thereby preventing its slipping off the pedicle The cervical attachments of the sacrocervical fascia are severed, permitting the uterine vessels to come into the operative field as the uterus descends are ligated on either side with a suture of chronic

Number 1 These vessels are severed parallel to the suture which is cut to permit the vessels to retract to a higher level. The oul-de-sac is opened and the fundus of the uterus delivered through this opening. The bladder is now elevated by inserting two fingers of the left hand while scissors held in the right hand open into the anterior space. Curved clamps from below and above, their points in apposition, clamp the structures adjacent to the uterme body on either side Sev ening of these structures permits the delivery of the uterus. Each pedicle is sutured with Number 1 chromic catgut before removal of the clamps. The sutures are left long to permit approximation of the stumps after peritoneal closure. Adnexal examination is done at this time and pathologic tissues removed. Should an examination of the cavity of the uterus reveal carcinoma, both tubes and ovanes are excised at this time If either or both fallopian tubes give evidence of inflammatory changes, removal is advisable. The peritoneal cavity is now closed with a running suture of fine chromic catgut. Both pedicles of the infundibulopelvio ligaments remain outside the closed peritoneel cavity and are now approximated by ligating the sutures previously left long The cystocele is next repaired by separating laterally and removing the redundant mucosa, ex posing the denser structures which are to be

approximated in the cystocele repair A suture of chromic catcut is now passed through the distal end of the fascia on the left side which was previously separated from the cervix, through into the central stump formed by the union of the infundibulopelvic ligaments and out through to the corresponding fascia on the right side. This suture remains lax at this time, thereby permitting a repair of the cystocele at a relatively low level. The cystocele is repaired with two or more layers of fine chromic catgut, approximating the tissues which previously had been damaged, permitting a cystocele to form. The connective tissue beneath the urethra is approximated, usually with a continuous suture of chromic 00 In joining these structures, interrupted chromic catgut sutures were used in the earlier operations, but seemed to bave no special advantage over a continuous su ture which is not drawn tight and the absence of buried knots favors smooth healing of the mucous membrane The two top autures, attached to the central stump previously mentioned are now threaded on a round needle and passed from within outward on opposite sides, catching supporting fascia, then passed through the mucous membrane one on either aide. Two more sutures from the central stump are used at a lower level while the remaining two are passed through the sacrocervical tissues and mucous membrane which were previously separated from the cervix.

The sutures are ligated in reverse order of their insertion

This method of suturing elevates the various vault to the highest position possible and joins the cardinal ligaments from side to side which were originally separated only by the cervix. operation is completed by repair of the rectocele. A central strip of mucous membrane is removed extending from the introitus to the cul-deopening, along the posterior vaginal The width of this strip depends upon the size of the rectocele to be repaired. The perirec tal fascia is now approximated with sutures of 00 chromic catgut, the levator fascia is approximated with interrupted chromic catcut sutures Number Approximation of the subcutaneous fascia in the penneal body is accomplished by a running auture through the fascia and returning upward as a subcutaneous suture A light pack of sterile gauge in the vagina and a retention catheter, to remain from twelve to forty-eight hours, com pletes the operation.

Statistics

Hydrosalpinx

present in 8)

Urethral caruncle

Third degree lacerations

The following statistics were compiled by Dr Barbara Beardslee from charts in the local hospitals of Burlington and appended by vaginal hysterectomics performed at Collee's Huntington Hospital and St. Lukes Hospital in Pasadena California.

Of the 1,000 patients under the care of Dr Oliver N Eastman, 522 were between 30 and 60 years of age, the youngest being 22, and the old est 84

CSL O'I	
Symptoms Bladder irritability Low backache Low abdominal discomfort Bearing-down discomfort Vaginal discharge Dysmenorrhea Stress incontinence	22- 186 14- 106 15- 56
Indications for Operation Prolapse of uterus Second and third degree prolapse Rectocele and cystocele Myoma uteri Metrorrhagia Postmenopausal bleeding Retroversion of uterus Carvical and uterine polypi Cystic ovaries Cul-de-sac hernia Malignamese of the fundus uteri Malignancies of the cervix	410 264 478 886 255 91 154 48 46 11 17
Preoperative Fundings Added to Indications for	Эрега-
tion Palvic inflammatory disease Ectopic pregnancy	23 2

Decubitus ulceration of cervix (malignancy

62	OLIVER N
Rectovaginal fistula Hemorrhoids Pyometria Bartholin duct cyst Cervical stenosis Recurrent appendicitis	1 18 5 4 3 2
Operations One thousand vaginal hysterectomics following operations	s include the
Cystocele repair Perineorrhaphy, including rectocele re Salpingectomy, alone Salpingo-oophorectomy	epair 967 97 90 9
Vaginal appendectomy Cul-de-sac hernia Urethral caruncle Rectovaginal fistula Bartholin duct cysts	15 6 1 5
Vagnal cyst Hemorrhoidectomy Immediately following vagnal hyste	2 29 rectomy the
abdomen was opened in 24 cases Appendectomy, abdominal	6
Ventral hernia and appendectomy Salpingo-oophorectomy Adhesions	2 8 2 3
Ovarectomy for large ovarian cysts Severing of previous ventral fixation Bleeding from left ovarian vein Myoma which separated from uterus	stump 1
Pathologic Diagnosis Leiomyoma uteri or myoma uteri	218
Endometrial polyps Endometrial hyperplasia Cystic endometrial hyperplasia Adenocarcinoma uteri	53 84 28 16
Adenomyosis uteri Squamous cell carcinoma, cervix Epidermoid carcinoma, Grade II	26 11 1
Adenomyosis of cervix Adenocarcinoma of rectum Papillary cystadenoma plus endo	
polypi with early malignant chang Leiomyomata, malignant Papillary cystadenoma of ovary Pseudomucinous papillary cystad	denoma
ovary Arteriosclerosis of uterine arteries Atrophic uterus Endometriosis uteri	1 2 48 8
Endometrial polyp, benign, cystic Endometrial polyp, benign, adenom Leiomyomatous uterus with hyline d	atous 6 legener-
ation Leiomyoma uteri, calcified Retained decidua Tubal pregnancy	$\begin{array}{c}1\\2\\7\\2\\2\end{array}$
Appendicitis Morbidity (Excluding minor complication)	-
Hemorrhage, with transfusion of b plasma, during or after operation Severe anemia, preoperatively, re-	lood or
plasma or blood Postoperative cystitis Pyelitis	11 25 6
Pelvic abscess Thrombophlebitis Pneumonia with atelectasis	6 4 2 3
Pneumonia Pelvic peritonitis	3 1

Deaths (Institutional)

In the first 500 cases there were six deaths 1 on day of operation, postoperative shock 1 on sixth day postoperative due to pneumonia following an atelectasis 1 on seventh day postoperative due to pulmonary

thrombosis 1 on ninth day postoperative due to intestinal obstruction

1 on thirteenth day postoperative due to peritonitis and pelvic abscess 1 on twenty-ninth day postoperative from peri-

tonitis-squamous cell carcinoma of cervix Grade III

In the second 500 cases there was one death, having the following autopsy report The patient was a woman, aged 31, who died thirty-six hours postoperatively Pathologic report Squamous cell carcinoma Grade III, high malignancy general peritonitis, streptococcic, pulmonary tuberculosis in hilar lymph nodes, large embolus in left heart, large thrombosis right ventricle with cardiac failure. This patient was bleeding continuously from inoperable carcinoma of the cervix Operation was performed to control bleeding which required continuous vaginal packings to control hemorrhage

Check-ups

Five hundred and forty-four patients of the series have been checked personally Cystoceles have recurred, small, medium, or large, in 36 instances, while rectocele recurrence was found in 8 instances Five of these patients have been reoperated

The malignancies in Group 1 and 2 numbered Thirty-one of these patients were alive on April 23, 1947

Check-ups Since March 11, 1947

Check-ups in office since March 11, 1947 105

2 Results

100% satisfactory 95% satisfactory 90% satisfactory 85% satisfactory 80% satisfactory 75% satisfactory 80 Failure

Depth of vagina in the 105 patients examined since March 11, 1947

Deepest vagina 14 cm. Shallowest vagina 6 cm Average vagina

4 Weakness of anterior wall in patients ex amined since March 11, 1947 17 None of these None of these patients complained of troublesome symptoms

Weakness of posterior wall in patients examined since March 11, 1947 2

Much appreciation is deserved by Dr Barbara Beardslee for the painstaking effort in reviewing this series of which only a preliminary report is submitted by the author The age groups and details of morbidity and mortality, are too voluminous to be incorporated in this paper

IS ANAL FISTULA A NECESSARY SEQUEL TO PERIANAL ABSCESS?

EMIL GRANET, M.D., New York City

CURRENTIA, hospital beds are universally at a premium and operating room facilities are soverely overtaxed. Any measure directed toward alleviating this deplorable condition is deserving of our earnest consideration. The advantage of obtaining a cure following the primary surgical treatment of a patient with perinant suppuration is obvious. Too often a residual fistula is the expected result entailing one or more hospital readmissions for further operation. Jackman reported recently that of 500 patients seen at the Mayo Clinic with anal fistula, 43 per cent, or nearly one half, had undergone from one to fourteen operations for this condition.

It is my intention to show that fistulas-in-ano often can be prevented if two surgical axioms are observed (1) that the optimum time for drainage of perlanal suppuration is at the earliest mement when this process is suspected by symptoms and physical signs, and (2) that in most instances it is possible and expedient to treat acute and chrone perlanal abscess in one surgical procedure, so that the infectious lesion is drained or excised completely, that is, from the primary source of infection in the anus to the remote perlanal or schlorectal abscess. Henceforth in this report the term "perlanal" will include ischlorectal and other infrallevator abscesses.

Contemporary opinions as to the management of penanal suppuration, especially in regard to those phases of the problem just stated are divergent or indecisive

Buie favors delayed incision and, in general, allows an abecess to approach the point of rupture before interfering 2 Smith and Vickers express identical views. 2.4 On the other hand, many of us agree with Allingham who, sixty five years ago stated "It is certainly less damaging to cut into an inflamed swelling near the anus without find ing pus than to let a day pass over after suppuration has commenced, the longer the abscess is left unopened the greater the danger of the formation of lateral sinuses." That this edict has been followed at St Mark's Hospital for decades is indicated by the current opinion of Gabriel who states, "Every anorectal abscess should be incised at the earliest possible moment It is not desirable to procrastinate and apply palliative treatment until fluctuation has oc curred, for abscesses in this region never clear up spontaneously " Horseshoe, perirectal, supralevator, and "water spout' fistulas are the fre-

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quent end results of such procrastnation on the part of the patient, the doctor, or both Perland suppuration must be treated as a surgical emergency In those cases in which hospitalization is necessarily delayed, a simple stab incision into the abscess, performed at the home, office, or clinic, will afford an external exit for pus under pressure thereby preventing circumferential spread

That "stem to stern" drainage of anorectal abscesses be utilized when possible constitutes my second premise Here again current opinions regarding this procedure are divergent or inde-Miller states "If an opening into the anal canal be discovered no attempt should, as a rule, be made to lay this open at the time of the primary operation. If a fistula results, it should be dealt with by operation a few weeks later "7 Buie, Manheim and Bacon are guardedly con servative 2.2.9 They extend drainage through the primary internal opening only in special instances when the abscess is superficial, localized, and the internal opening easily located However, in a recent article Bacon16 has crystallised his opinion and states that he attempts operation for abscess in one sitting "We have performed this maneuver in selected cases in several hundred in stances and seldom have encountered a recur rence," said Bacon.

In naval personnel hospitalized for perianal abscesses my utilisation of the one-stage operation resulted in wounds that healed without fistulas, thereby minimizing hospital morbidity and permitting early return to duty

Pathologic Physiology

Successful therapy in medicine is dependent, primarily, on a lucal understanding of the pathologic physiology resulting in a specific lesion. It is probable that most perianal abscesses originate in the anus Several anatomic structures, most important of which are the anal crypts, ducts, and intramusoular glands, are involved The latter were first described in 1880 by Harmann and Desfosses who pointed out their etiologic importance in producing perianal fistulas

In 1914 Franklin P Johnson published comprehensive studies on the embryology of the rectum in which he emphasized the development of the intramuscular glands. This early, complete, and detailed description is of great significance to the problem of perianal suppuration Johnson described gland-like, simple or branched tubules lying completely in the submucosa known as the intramuscular glands. There are

Presented at the meeting of the New York Proctologie Society April 10 1947

seldom more than six or eight of these. The main ducts of the glands penetrate the internal sphincter muscle to terminate blindly in the intramuscular connective tissue.

Johnson's description of the anal ducts and intramuscular glands was confirmed and subsequently elaborated on by Harris, Lockhart-Mummery, Gordon-Watson, Pope, Tucker and Hellwig, and, currently, by Kratzer and Dockerty Harris found that occasionally these glands after penetrating the internal sphinoter spread to the superficial surface of the levator am and so into the ischiorectal fossae, or to the deep surface of the levator and so to the supralevator space 12 It is obvious, as Lockhart-Mummery pointed out, that "these glands communicating as they do with the bowel lumen, afford a path for infective organisms to reach the connective tissue of the ischiorectal fossa and so set up an abscess in this region "13

Gordon-Watson and Dodd demonstrated that infection can take place primarily in the gland when there is no direct communication with the anal canal ¹⁴ Evidence of primary gland infection is offered in serial sections of fistulous tracts examined after excision by these authors Portions of the intramuscular gland substance inhed by transitional epithelium are clearly shown to be involved in a localized abscess process. In these instances the ducts communicating with the anal canal may have been obliterated during development and/or the anal orifices of the ducts become blocked by the congestion of the mucosa or submucosa. Kratzer and Dockerty in a current report confirm this opinion ¹⁵

That the crypt opening into the anus sometimes is sealed is common experience. Even in operation for fistula-in-ano, search for the internal anal opening by probe occasionally fails and it can be demonstrated only by the injection of dye under pressure through the external opening Failure to cure a fistula usually is attributed to the fact that the true internal opening has been unintentionally spared In my experience search for the internal anal opening of a crypt, tubule, or intramuscular gland by means of a probe from the anal side was seldom successful in the presence of an acute abscess Mucosal edema, induration, and inflammatory obliteration of the crypt were probable factors contributing to the failure of this maneuver Obviously in an acute abscess the injection of dye is unfeasible most of our acute abscesses, however, the anal source of infection was found by retrograde probe exploration following incision of the abscess

Fistula-in-ano commonly is regarded as the contracted, fibrotic end result of an externally drained perianal abscess. As shown, the source of such an abscess usually is found in a crypt,

tubule, or intramuscular gland. If this focal source of infection in the anus is removed at the same time that the abscess is drained, it is logical to assume that a fistula-in-ano cannot result. Of 48 consecutive patients with infralevator perianal abscess recently treated, this one-stage "stem to stern" operation proved feasible in 40".

Method of Treatment

One hundred and twelve consecutive cases of perianal inflammatory disease were treated surgically at the US Naval Hospital, St Albans, New York, in a recent eighteen-month period Of these, 60 were fistulas-in-ano. The remaining 52 were patients with perianal abscesses, 36 acute and the remaining 16, subacute or chronic (Table 1)

TABLE 1.--TOTAL PERIANAL ABSCESSES

Description	Number		ns Mui-
Acute abscess with sinus to anus		•	3
Chronic abscess with	28 (58%) 8 (16%)	^{2%} 8	
Acute abscess without	4 (8%)}	4	
Chronic abscess with- out sinus	4 (8%) 1 (2%)	υ% 1	
Abscess origin in anal	4	4	
Abscess origin in pilo- nidal disease	3	3	
Recurrent abscess with aupralevator sinus	3		8
Acute supralevator ab-	1		1
Total	52	45	7

The term, chronic abscess, as used in this report requires elucidation. Patients so classified developed an acute perianal abscess at sea or at a remote naval station. Spontaneous rupture of the abscess had occurred some days or weeks before the patient arrived at our hospital with an indurated, inadequately draining wound. In some, the medical officer or corpsman had incised the abscess, thereby relieving pain and limiting circumferential spread. Definitive treatment of these subacute or chronic lesions simulated that of our acute abscesses except for the first maneuver, the exploratory stab

Caudal anesthesia combined with second sacral block anesthesia was used in 32, intravenous sodium pentothal in 16, and spinal anesthesia in 4 of 52 cases of perianal abscess. The prone "jackknife" position with buttocks retracted by adhesive straps was found to be convenient and practical

The t ment of an acute, right, posterior ischior, abscess is as follows. The adequate of the explored digitally and by hooked prob in an attempt to find the anal source of in-

fection If not immediately successful, the search for the primary sinus is abandoned as, in my opinion, prolonged probing in these cases is meddlesome and of little value in acute abscess

With a scalpel an exploratory stab incision is directed cephalad and medially toward the center of the indurated abscess. Following the evacuation of pus the stab incision is enlarged in a direction parallel to the external aphineter muscles so that an exploratory finger can be in serted. Finger investigation determines the extent of the abscess cavity and breaks down residual fascial septa and secondary abscess pockets. With blunt seasors introduced over the exploratory finger, the wound is enlarged to the anterior and then to the posterior limits of the abscess cavit.

Anteroposterior perianal incisions favor drain age for two reasons. One, the fibro-elastic septal insertions of the longitudinal muscle of the rectum which course radially or spoke-like from the anus are cut across, thereby draining individual fascial spaces. The "fish mouth" or "hockey stick" incision serves the same purpose in draining an anterior closed space infection of the finger. Two, by its approximation to the sphincter muscles the medial wall of the abscess cavity is drawn inward and away from the fixed lateral wall. The wound edges are separated thereby, so favoring drainage. In contrast radial perianal in cisions tend to close when the sphincter contracts.

A blunt, curved hemostat is utilized as a probe in seeking the tract leading from the abscess cavity to the primary source of infection in the anus This tract is found easily in most cases and the point of the hemostat can be palpated just beneath the anal mucoderm A probe pointed grooved director is substituted for the hemostat and an internal opening is sought patients the probe readily emerged in a posterior crypt. In many others despite careful search the probe point remained in the submucosa with only the mucosa or anoderm separating the probe point from the palpating index finger probable that in these cases the primary source of the abscess originated in an anal duct or an the anal canal was provented by the sealing of the crypt or distal portion of the duct through developmental or inflammatory changes as sug gested by Gordon Watson

It is obvious that one cannot retreat leaving a virulently infected submucous nus tract. I elect, therefore, to push the propertitiough the mucosa while held at right angles it it pourse of the fibers of the external sphincter, it. Hes A fistulous tract thus is established from the internal opening in the anus to the external opening in the anus to the external opening in the second of the second opening in the second of the second opening in the second opening in the second of the second opening in t

ing in the drained abecess. The tissue and sphincter muscle overlying the grooved director is incised by scalpel directed along the groove The abscess is drained thereby from the "stem" in the anus to the "stern" in the abscess cavity The skin and subcutaneous tissue overlying the abscess are removed and the wound edges are cut well back to saucenze the wound adequately Overhanging skin edges are not tolerated incised tract into the anus is dealt with similarly so that, following excision of the edges, the wound should resemble a shallow trough After hemostasis has been assured, moistened iodoform gauze is packed into the abscess cavity and secured by adequate superficial dressing separate sliver of gauge is laid in the anal wound to be extruded with the first defecation pack is removed from the abscess on the fourth postoperative day at which time the necrotic abscess base has sloughed off to a large extent.

Results

In 40 of 43 patients, treated in the manner described, the lesion was healed by complete epithelization in four to eight weeks. In 3 patients a secondary internal opening was found at or above the anorectal ring. In these a two-stage 'scton' operation was performed. In 5 patients with typical infralevator abscesses a sinus tract leading toward the anus could not be found. These patients were treated by saucerization of the abscess and healed uneventfully.

There were 4 patients with a perianal abscess originating in a chronic anal fissure. These were treated first by drainage and saucerization of the abscess and then by excision and definitive treatment of the anal ulcer.

Two patients had perianal abscesses from which a sinus tract led posteriorly to the source of in fection in an inactive pilonidal cyst. Another patient in this group had bilateral abscesses, each of which was connected to a pilonidal dimple, the common source of origin of the abscesses

Three patients with chronic fistulas had recurrent perianal abscesses. At exploration, sinus tracts were found which led cephalad into the supralevator space

Only one acute supralevator abscess was en countered This occurred in a Navy diver who was operated on five days after the onset of symptoms. The relative infrequency of supra levator abscess is commented on by Gabriel who found only 4 (3 per cent) in 132 consecutive ad missions to St. Mark's Hospital for the treatment of anorectal abscess 6

Summary

1 In most instances an anal fistula results when a perianal abscess has been incompletely

Surg Gynes

This sequel usually drained by local incision can be prevented if the abscess is afforded early dramage, not only locally, but at the source of infection in the anus

Contemporary literature regarding these points is quoted to show that even authoritative opinion on the management of this problem is divergent and indecisive

Because of its importance to the problem, the development of the generally accepted concept that perianal suppuration has its source in anal crypts, ducts, or intramuscular glands is reviewed in detail Evidence that a source of perianal infection can exist in the intramuscular glands or anal ducts without a patent communi-

cating tract to the anus is presented For this reason sometimes it is impossible to demonstrate an internal sinus opening in performing fistulectomy In such instances failure to find and remove the infectious source in the anal duct or intramuscular gland results in persistence of the lesion Inasmuch as a perianal abscess is the precursor of a fistula, it is essential that concurrent with surgical drainage of the abscess, the associate infectious source in an anal crypt. duct, or intramuscular gland be sought for and excised If this is accomplished, a fistula cannot result

The technic of "stem to stern" drainage in the surgical treatment of perianal abscess is described This one-stage operation proved feasible and resulted in uncomplicated healing in 40 (93 per cent) of 43 patients with infralevator This experience demonstrates that anal fistulas probably can be prevented in most instances, if acute perianal abscesses are drained early and completely from "stem to stern"

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ANNOUNCE BOARD EXAMINATIONS

The American Board of Obstetrics and Gynecology, Inc, has announced that the next written examination (Part I) for all candidates will be held in various cities of the United States and Canada on Friday, February 6, 1948 at 2 00 P M Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year

A number of changes in Board regulations and requirements were put into effect at the last annual meeting of the Board held in Pittsburgh, Pennsylvania, from June 1 to June 7, 1947 Among these is the new ruling that the Board does not subscribe

to any hospital or medical school rule that certification is to be required for medical appointments in ranks lower than Chief or Senior Staff of hospitals, or Associate Professorship in Schools of Medicine, for the obvious reason that such appointments constitute desirable specialist training. At this meeting the Board also ruled that credit for graduate courses in the basic sciences which involve laboratory and didactic teaching rather than clinical experience or opportunities will be given credit for the time spent up to a maximum period of not more than six months regardless of the duration of the course

THE PRACTICE OF MIDWIVES IN NEW YORK CITY

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(From the Bureau of Child Hygiene New York City Department of Health)

THE practice of midwifery has changed I markedly since the turn of the century Prior to 1907 midwives were required simply to appear at the office of Registrar of Records to register their signature and present certificates of character and experience from two physicians No supervision was maintained over their practice In 1907 the New York State Legislature passed an act which tested the regulation of practice of midwifery in the Board of Health In 1909 this supervision was placed in the Bureau of Child Hygiene and Section 196 of the Sanitary Code was enacted In 1913 a Midwif ery Division was created The same year the Bellevue School for Midwives was opened and continued to function until 1936

In November 1933 the New York Academy of Medicine published a study of the maternal mortality in New York City from 1930 to 1932 Releases to the press from this report included statistics purportedly indicating that delivery in the home was safer than delivery in the hospital and that the midwife was responsible for only a small percentage of maternal deaths as compared to the physician.1 The better results of home deliveries were attributed to 'spontaneous deliveries and uncontaminated surroundings with proper attendants Operative deliveries anal gesin and anesthesia were described as signifi cant factors in raising maternal mortality The report stated that "it would appear that domiciliary obstetrical practice must undergo further con aderation and probable re-evaluation" and contrary to the generally accepted opinion the midwife is an acceptable attendant for properly relected cases of labor and delivery " Yet elsewhere in the chapter on midwifery one finds the following paradoucal paragraph 'A large num ber of the practicing midwives in New York City are foreign-born women who trained in the coun try of their birth and came to this country before the present laws regarding licensure were put into effect. There is no provision in the law for examination or refresher courses. It is a little hard to believe that a woman of sixty wholly illiterate, trained forty years ago and having no further study since that time can be a safe attendant for a woman during her pregnancy and

In March, 1934, the New York Obstetrical Society appointed a committee to review this report of the Academy of Medicine, and the following month a critical analysis was presented The Obstetrical Society pointed out that the question of home versus hospital delivery resolved itself into differentiation of adequate and inadequate hospitals, and that delivery in a well organized and well-equipped hospital was defi nitely safer than home delivery 2. The relatively high number of hospital fatalities referred to in the Academy report were explained by the bad cases which had been started in the home Obstetrical Society also pointed out that, although it was an almost impossible task to ascribe responsibility of maternal deaths, any figures used to compare the results of midwives and physicians should have been based on the percentage of deliveries each group performed rather than on the percentage of total preventable deaths since the midwife performed only 8 per cent of the total deliveries

When the former method of comparison was used there was actually a higher percentage of preventability in the deaths among women at tended by midwives than among the cases in general or among those delivered at home by a The Committee further stated that physician "operative deliveries in skilled hands were necessary merciful and lifesaving' and that they constituted one of the great advances of modern obstetrics tending to lower maternal mortality rather than increase it. Anesthesia and anal gests were described as not only humane but tending to prevent unnecessary and too early interference with the natural processes of labor and per se did not add to the maternal or fetal death rates nor to operative interference. The Committee concluded that the practice of obstetrics would never be elevated to the position it rightly deserves so long as the midwife was per mitted to practice "There is need of apprecia tion of the inadequacy of any system which in troduces incompetency in competition with scien-The midwives are a menace to tific knowledge the health of the women under their supervision and the care of the expectant mother is too important and technical to be entrusted to attend ants without complete and adequate training

delivery 1 et, such women are practicing mid wifery in New York City"

Presented at a meeting of the Section of Obstatrics and 27 secology of the New York Academy of Medicine January

In 1937 the Sanitary Code was revised requiring annual relicensure of all midwives Subsequent revision in 1944 prohibited the midwife from delivering abnormal cases and required her

to deliver at least one case a year to qualify for relicensure The Code also provided for referral of all cases to a physician or clinic for prenatal care and blood test, and notification of the Health Department upon registration of new cases Further provisions were made for summoning the

Further provisions were made for summoning the aid of a physician

The present supervision of midwifery may be outlined as follows. Every three months a field nurse from the Health Department visits the midwife in her home to inspect her equipment, records, and premises. The records include a quarterly report of all cases with regard to antepartum care and blood test, type of delivery, postpartum examination, and complications. These quarterly reports are also reviewed at the

District Health Center and at the Bureau of Child Hygiene A field nurse sees all midwives' patients antepartum and postpartum. In the event of any irregularities the midwife is summoned, instructed, and warned

The midwives have served a group of women in whom custom and superstition prevented care by a physician. As these customs and superstitions changed with education of the public and expansion of hospital facilities, the need for midwives' services has decreased. Table 1 presents a picture of the decreasing role which the midwife has played, and shows that the midwives now perform less than half of one per cent.

TABLE 1—Number of Midwives Number of Midwife Deliveries and Percentage of Total Deliveries in New York City—1909-1945

of all deliveries in New York City

Year	Number of Midwives	Number of Midwife Deliveries	Percentage of Total Deliveries
1909	3 181	49 616	40 3
1919	1 695	41 876	32 1
1929	1 229	12 505	10 0
1939	273	1 600	1 5
1940	233	1 311	1 2
1941	193	999	0 9
1942	201	1 147	09
1943	156	750	0 6
1944	128	547	0 4
1945	116	492	0 4

A detailed analysis was made of the 750 deliveries in 1943 and of the 492 deliveries in 1945 performed by midwives. Despite the fact that the Sanitary Code was amended in 1944 and a refresher course held the same year, there was no change in the quality of maternity care in this two-year interval. Analysis of the 492 deliveries performed by 116 midwives in 1945 follows. The data to be presented were obtained from personal interviews with the midwives and from their quarterly reports. It should be

pointed out that the latter were often incomplete, inaccurate, and, in some instances, deliberately

The age range of the midwives is shown in Table 2

TABLE 2 -Age of MIDWIVES

TABLE 2 -AGE OF MIDWINES		
Age	Number of	
Range	Midwives	
35-39	4	
40-44	9	
45-49	19	
50-54	20	
55 - 59	20	
65-69	15	
70-7 4	7	
75+ Total	116	
50-54 55-59 60-64 65-69 70-74 75+	20 20 21 15 7	

Eighty-four of the 116 are over 50 years of age, and 23 are over 65 years of age The youngest is 36, and the oldest is 85

Table 3 shows where the 116 midwives received their training

TABLE 3 -PLACE OF TRAINING OF MIDWIVES

	
Place of Training	Number of Midwives
United States	83
Italy	25
Germany	2
Norway	1
Austria	1
Russia	1
Hungary	1
British Guiana	1
British West Indies	1
Total	116
	110

Eighty-three of the 116 midwives were trained in the United States Sixty of these were trained in the Bellevue School, 12 in the Columbia School, seven under New York City physicians and four in a variety of other places Twenty-five were trained in Italy

Table 4 shows the year of the midwife's training

TABLE 4 —YEAR OF MIDWIVES' TRAINING

TABLE 4 - I DAR OF MIDWIVES TRAINING		
Year	Number of Midwives	
1870-1879	1	
1880-1889	ñ	
1890-1899	ă	
1900~1909	3 25	
1910-1919	29	
1920-1929	35	
1930–1939	17	
No date	6	
m 1		
Total	116	

Fifty-eight midwives (50 per cent) received their training before 1920, and 93 (80 per cent) received their training before 1930 Furthermore, a good number of these women are illiterate These facts indicate the scope of the educational problem

Table 5 presents the legal history of the 116 midwives up to January 1, 1946

TABLE 8.—Legal History of Midwives Up to January 1

	Mid	lwives
Status	Number	Percentage
Not arrested	8"	75
Not arrested Arrested	20	25
Total	116	100

Twenty nine, or 25 per cent, were arrested because of suspicion of performing abortions

Table 6 presents additional data on the 29 midwives who had been arrested because of suspicion of performing illegal operations

TABLE 6.—Analysis of 29 Midwites Arrested for Performing Arbeitons

Number of Midwives	Total Arrests
17	17
7	14
3	9
3	8
	
~າງ	48
	≯lidwives

Despite the fact that the offenses were repeated, convictions were rare and frequently rescinded upon appeal

Table 7 shows the number of deliveries per formed by the 116 midwives

TABLE 7 -NUMBER OF DELIVERIES DONE BY MIDWIVES

Number of Deliveries	Marian at Mill day
	Number of Midwives
ų	24 16 20 13
<u> </u>	16
•	‡ 0
:	13
ī	9
× ×	9
¥	5
.	<u> </u>
ă	<u>I</u>
8 9 10	•
11 12	†
12	į.
13	\$
14 17	•
17	î
19	ī
21 23 37	ī
73	ī
23	ī
a7	1
Total	
10(4)	116

The number of deliveries ranges from 0 to 37 per mulwife Approximately 90 per cent of the 116 mulwices performed five or less deliveries in 1045. If one assumes that proficiency requires constant practice it is obvious that at least 90 per cent of these midwives did not have the opportunity to remain proficient in obstetrics. The data also indicate that these midwives cannot be dependent upon their practice for a livelihood.

Table 8 shows the time that antepartum care was begun and the time the serologic test was per formed

TABLL 8.—TEIMESTER OF PRECNANCY ANTEPARTUM CARE WAS BEGUN AND WASSERMANN WAS TAKEN

	Number of Patients Beginning Ante-	Number of Patients Having Blood
	partum Care	Test
First trimester	43	24
Becond trimester	138	137
Third trimester	158	-39
No care	142	43
No information	11	49
Total	402	492

One hundred and forty two patients (30 per cent) had no antepartum care, and forty three patients (9 per cent) had no serologic test. One hundred fifty-eight patients (32 per cent) had antepartum care begun in the third trimester and 230 patients (40 per cent) had serologic tests performed in the same period of pregnancy. Only 43 patients (9 per cent) had antepartum care in the first trimester, and only 24 patients (5 per cent) had their blood test in the same period. In 10 per cent of cases there was no information regarding serologic tests. This illustrates the in adequate care which the patients receive and also the meaningletoness of the midwives' records.

Table 9 shows the information regarding post-

TABLE 9 -- Data on First Possesser Franchiston

INDER W-DITE OF PRACT OFFICE	EXAMINATIO
Had postpartum examination	140
No postpartum examination No informati-n	323 21
Total	402
	407

Three hundred twenty two patients (70 per cent) had no postpartum examination, and it is unlikely that the 21 concerning whom information was lacking had any different care.

TABLE 10.—STILLBIRTES

		111011111111111	C.IIIIIII
Caso	Month Prenatal Care Begun	Month Blood Test Performed	Comment
		8	
1	8	8	Baby macerated. Physician called during labor who fetal heart lost." Midwift had 6 deliveries in 1945.
2	8	None	Fetal beart lost during labor Cord three times around neck Physician not called Midwife had 9 deliveries in 1945.
3	8	8	Physician had told midwif- case was abnormal but mid wif continued care. Fi- nally sent to bospital in labor- with prolapsed cord and toxerola. Same midwife as Case 2.
4	None	None	No physician called Midwife had three deliveries in 1945
5	7	8	Patient had had previous still birth. Physician called after delivery blidwife had 22 deliveries in 1945.
6	None	7	No physician called. Midwife had 21 deliveries in 1945.
7	None	Yon•	Physician called when breech presentation recognized late in labor Midwife had 4 de- liveries in 1045.
8	4	None	Physician not called. Midwife had 17 deliveries in 1945.

Table 10 presents the data on stillburths for 1945

There were eight known stillbirths giving a stillbirth rate of 16 3 per 1,000 deliveries. Whereas this may not appear high at first glance, it must be remembered that neonatal deaths are not included and these account for as much as 50 per cent of fetal mortality. None of the cases had adequate care. Antepartum care and blood tests were performed late or omitted.

There were no maternal deaths in the 492 cases which could be attributed to the midwife. The Sanitary Code stipulates that the midwife shall not handle abnormal cases, yet 2 known cases of tovemia, both resulting in eclampsia, and 5 known cases of breech presentation were managed by the midwives. This can be explained only by inability of the midwives to recognize abnormal cases or refusal to abide by the

Medical assistance was called for in only 31 out of the 492 cases and most of the time too late, i.e., after hemorrhage, laceration, retained placenta, or loss of fetal heart. In several instances the midwife had not recorded this information or had deliberately falsified it. One midwife's patient was brought into a hospital, after attempted abortion, with a loop of bowel protruding from the vagina

Discussion

The data presented reveal that the midwife now performs less than 0 5 per cent of deliveries in New York City Half of the midwives received their training twenty-five or more years ago good number are illiterate and are too old to attend any regular classes, so that it is practically impossible to undertake any educational program to acquaint them with modern standards of maternity care Ninety per cent of the midwives performed five or less deliveries in 1945 It is obvious that it would be difficult for them to retain their skill in obstetrics with such a small practice, and it is equally obvious that these women cannot be dependent upon their lawful practice for a livelihood The legal history presented sheds light on their extracurricular activi-

This study clearly indicates that the majority of patients delivered by midwives in New York City received maternity care which may be classed as inadequate. Antepartum care and blood tests frequently are omitted or performed late in pregnancy. Most patients have no postpartum examination. Furthermore, the midwives delivered cases prohibited by law because of abnormalities such as toxemia, abnormal presentation, and positive serology, and not infrequently the records were falsified deliberately.

Provisions for summoning the aid of a physician were ignored, or such aid was called for too late Analysis of the stillbirths reveals that none of the cases received adequate care. Whereas the stillbirth rate is not remarkably high, neonatal deaths are not included, and as previously stated these neonatal deaths account for as much as 50 per cent of fetal mortality.

Interviews with 116 midwives resulted in 56 accepting retirement certificates. A detailed review of the records of the remaining 60 was presented to the Midwifery Board, and the Board of Health saw fit to deny renewal of midwifery license to 29 because of violations of the sanitary code. Although there remain but 31 midwives, it would seem high time for New York City to write the final note in this archaic phase of obstetrics. It is hoped that other cities will follow example, lest the current hospital bed shortages temporarily encourage a return to midwifery. Such shortages are being met satisfactorily by employing early ambulation pending further expansion of maternity services.

Stander³ has summed up the problems as follows "No case in obstetrics is simple and safe and should not be so regarded until you have a healthy mother and baby at the end of the puerperium There is no other field in medicine where a perfectly healthy patient can suddenly, within minutes, become a seriously and fatally ill This holds true just as much for the multiparous woman as for the primipara provement in obstetrics cannot be accomplished by reverting to an archaic form of midwife practice by which two lives, those of the mother and her child, are entrusted to the hands of persons uneducated and untrained in most of the fundamental medical sciences and only partly schooled in one of the clinical branches of medicine, without any knowledge whatsoever of gynecology, an absolute essential in the workup of anyone who undertakes the medical supervision of pregnancy and parturation If we really believe that the midwife can replace us in this work, it is time for us to consider whether there is any sound excuse for the existence of our medical schools, as far as obstetrics is concerned I would no more wish to see the surgeons hand back some of their operating to the barbers or barber surgeons, than I would nant to have us, obstetricians, revert back to our own ancestral system of midwives"

Summary

A brief history of midwifery practice in New York City, demonstrating the constantly diminishing role which the midwife is playing in obstetric practice, is presented. The inadequacy of midwife maternity care is demonstrated and some of the reasons for the analysis.

Conclusion

The practice of midwifery in New York City should be abolished

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THE DODO FLIES AGAIN With the adjournment of the 1917 California State Legislature and more recently with the ad journment of the first session of the Lightieth Congress, word has been passed around in some medical circles that the issue of compulsory health insurance is as dead as a dodo. While such word is reassuring, we are beginning to wonder whether we should accept it as gospel.

A few recent incidents might serve to refresh our memories and to give us pause to consider whether or not compulsory health insurance has actually died Possibly it has only gone to sleep to awaken at a

more propitious moment

Consider for instance the action of the California State Federation of Labor (A. F of L.) in circulat ing a statement before the Senate Subcommittee of the Committee on Labor and Welfare a statement which branded the California Medical Association with asserted unconsciousness to public needs and disregard for sound social betterment

Consider again the State Federation of Labor in writing to every member of the California State Logulature to blast the C.M.A for introducing a legislative bill which would ease the burden of selling voluntary health insurance by simplifying the selling process without depriving any individual of the right of self-determination. The State Federation of Labor calla this compulsory health maurance which it claims is a medical scheme to channel all voluntary health insurance into the hands of the doctors.

These items are in the record now and after a one-day spell, out of the headlines. However they are still in the minds of some legislators Likewise in the legislative minds are memories of a recent labor blast against Senator Robert A Taft of Ohio who was accused in a labor convention of being anti-labor because he had opposed a health insurance program which the convention labeled as President Truman's but which we refer to as the Wagner Murray Dingell Bill Senator Taft may be vulner able to labor's attack on other grounds but this one is something new

The final consideration is in the program of the California State Democratic Party which has adopted health insurance as one of its goals has just happened and it means that every Democratic candidate in this state may be called upon by his party to espouse this brand of social soothing вутир

The labor actions mentioned here might be ex pected as a part of labor's program of demanding its own way But when these moves impinge upon the collective mind of the law making bodies of the country they represent political action they enter that stage they represent a problem which organized medicine must meet if socializations of medical practice is to be avoided Medicine has the weapons available to it to wage the fight needed all it needs is the will to use these weapons the medical sootheayers have their way organised medicine would stack its weapons behind the door to collect dust

If the threat of socialized medicine is properly described in simile with the dodo we strongly suspoet that the ornithologists are misinformed as to the death of this bird -California Medical Septem

ber 1947

DEADLINE ANNOUNCED FOR APPLICATIONS

Applications for Part I of the examination of the American Board of Orthopedic Surgery must be received by the secretary Dr Francis VI McKeever 1136 West 6th Street, Los An-

goles 14 California not later than January 15 1948 Information relative to examining centers and dates will be announced at a later date according to the secretary

MODIFICATION OF THE INCISION FOR LAPAROTRACHELOTOMY

J THORNTON WALLACE, MD, FACS, and HARVEY J MERK, MD, Brooklyn, New York (From the Department of Obstetrics and Gynecology of the Brooklyn Hospital and the Long Island College of Medicine)

IT HAS been the experience and observation of the writers that incision of the uterine wall in low-flap cesarean section is a procedure oftentimes accompanied by haste, much blood and ammotic fluid, and at least some "blind surgery" as a result of the presence of this blood and fluid This is true to a greater extent when the incision is transverse rather than longitudinal, as the farther out to each side the incision is extended. the larger and more abundant is the blood supply It is also more likely to occur if the patient has not been in labor, with a consequently thicker lower uterine segment The natural tendency when brisk bleeding from the incised uterine wall is encountered is to make greater haste in completing the incision and extracting the baby and placenta, whereas the more logical procedure would be to pause and secure hemostasis instead

This bleeding, if not controlled, will continue until well after delivery of the baby and placenta. A method whereby this type of bleeding may be controlled promptly as encountered, along with certain other advantages, will be described

Quite by accident, when doing a repeat cesarean section in which there was a small rupture of the uterine scar with a pouch of membranes protruding through it, the idea occurred to the senior author that he might be able to complete the entire incision in the thinned out lower segment without rupturing the membranes. This was accordingly done with surprising ease. In this particular case, there was a minimum of bleeding and the entire incision was made without haste or guesswork as to its proper length before rupture of protruding membranes.

Since that time all the cesarean sections done by the writers and a large majority of those done by other members of the staff of the Brooklyn Hospital have been performed with this idea in mind

As most of our sections are now done under fractional spinal anesthesia, no initial haste in getting the baby out is necessary

Technic

After dissecting the bladder flap up and off the lower uterine segment, being careful to get into and remain in a relatively bloodless plane of cleavage, an incision 2 cm long across the mid-

line, low in the thin lower segment, is begun and carefully carried through the wall, layer at a time, until the membranes are reached and exposed (Fig 1)

As the membranes are approached greater and greater care must be exercised to avoid rupturing them Bleeding in this area is usually minimal Should this not be the case, another such area on one side or the other of the originally selected site for incision may be found to be less vascular (Fig 2) A Ford T clamp is placed on both the upper and lower edges of the incision to act as tractors as well as hemostats The opening which thus has been made in the uterine wall is just about large enough to admit the index finger comfortably The membranes are now "stripped loose" from the overlying uterine wall laterally on either side beneath the line of proposed incision in the uterine wall just as they are sometimes "stripped" vaginally through the cervix to induce labor Some of our operators have pre-

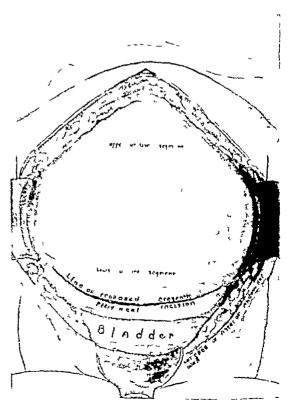
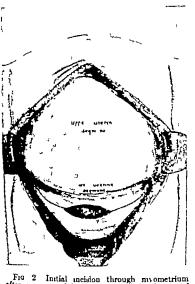


Fig 1 Exposed uterus before reflexion of bladder

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Obstetrics and Gynecology May 8 1947



after exposure of lower segment by reflexion of bladder flap.

ferred doing this with the handle of a knife or curved scissors (Fig. 3)

Bandage sensors are now introduced and the incision carefully extended far enough to the right for two fingers to be introduced between the membranes and uterine wall The incision may now, without haste be carried laterally as far as desired, either with bandage scissors or a knife, and with the fingers underneath the uterine wall to protect the membranes. This procedure is now repeated on the left When a large vessel is opened a long handled Ford clamp is applied to act both as a hemostat and later as a tractor If the uterine wall is so tightly drawn over the presenting part that fingers cannot be inserted beneath it, the incision may still be carried for ward with bandage scissors alone with but little more danger of rupturing the membranes. The field may thus be kept virtually dry and much subsequent blood loss prevented during the delivery of the baby placenta, and repair of the in cision (Fig. 4)

When the incision has been enlarged to the necessary length and hemostasis obtained, a small opening is made in the protruding membranes and a suction tube introduced through it. This usually may be done in such a way that most of the ammiotic fluid can be removed from the

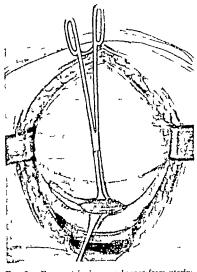


Fig. 3 Finger stripping membranes from uterim wall

uterine cavity before opening the membranes throughout the length of the mension The long handled Ford clamps are now turned up or down depending upon whether they are on the upper or lower edge of the incision, to get them out of the way, and the baby and placenta delivered in the usual manner These clamps originally are set in such a way as not only to obtain hemostasis but to outline the angles and upper and lower edges of the incision as well They now may be lifted up in line and repair of the incision may proceed in a practically bloodless field. It is wise to count the Ford clamps set along the incision and to make certain that all are accounted for at closure, as one occasionally may pull off a very thin uterine wall However this usually may be prevented by setting the outside blade of the T clamp far enough back on the uterine wall to in clude a good bite of tissue before closing and locking it (Fig. 5)

The advantages of this procedure are several Even if the operation is under general anexthesia the added two or three minutes consumed in making the incision in this fashion are more than compensated for by the decreased blood loss to the mother and the consequent increase in oxygenation of the baby's blood. The danger of making too small a uterine inclision with tearing at the

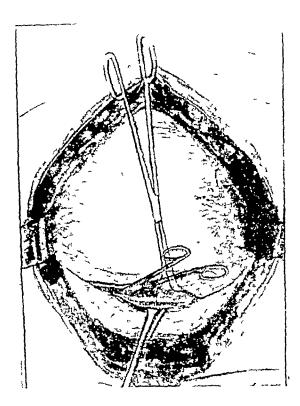


Fig 4 Completion of uterine incision with bandage

angles in delivery of the vertex definitely is lessened Enough time may be taken under unobscured vision to curve both ends of the incision well upward so that if perchance there is tearing, it will be in this direction rather than laterally It will make it virtually impossible to suture the upper edge of the incision to the posterior wall of the lower uterine segment instead of the lower edge of the incision, as has been done in the past If carried out successfully, it will be impossible for the operator to cut a baby's face or other part, as likewise has been done. It gives time and opportunity for making the incision smooth and even, rather than ragged and irregular With care it can be done in practically all cases in which the membranes are intact

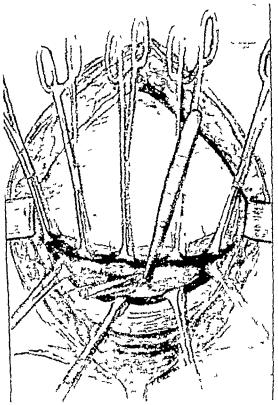


Fig. 5 Ford clamps in place, incision of the ammotic sac

and in a majority of those in which the membranes are ruptured. We have used it in extraperitoneal sections and in sections where a longitudinal rather than a transverse incision was used. In 2 cases of placenta previa, the condition in which this technic is most likely to fail, the edge of the placenta has presented in the incision. In both instances the placenta was pushed down, the membranes ruptured well above the presenting edge, and the baby extracted before the placental bed was disturbed

Note The authors wish to express their gratitude and appreciation to Miss M Ludeman for her cooperation in preparing the drawings used in illustrating the text and to Drs. John Casagrande and Florence Wilson for the use of their material in the preparation of the motion picture film used in connection with the presentation of this paper

KING'S ENGLISH SIMPLIFIED

From a prominent medical journal, in an article dealing with the "metabolism of natural estrogens," the following illumination was gleaned—"The chromatographic dispersion of the estrogens in these aliquot portions of the cluate is similar to that shown by ternary mixtures of crystalline estrone estradiol, and estriol in pure solution"

JAUNDICE AND LIVER FUNCTION TESTS

To What Extent Are They Necessary?

Brron D St John, M D Port Washington, New York

(From the Meadowbrook Hospital)

TAUNDICE is a yellow staining of the skin, I mucous membranes, and conjunctive by the escape to these tissues of an excess of bile pig ment (bilirubin) built up in the blood bilirubin appears in the urine and aweat, but is absent from the stool, cerebrospinal fluid, and salıva

Physiology of Jaundice

Bilirubin is formed by the destruction of red blood cells in the reticuloendothelial system, such as bone marrow, spleen, and liver This is proved by the fact that there is more bilirubin in the blood of the splenic vein than in the blood of the spleme artery Normally there is present 0.2 to 0.8 mg. per cent of bilirubin in the blood bilirubin travels to the liver where it is removed from the blood and goes through the biliary tracts to the common duct and then to the duodenum where, by the action of bacteria, it becomes urobilinogen Some of this urobilinogen passes through the intestinal tract and becomes oxidized to urobilin A small amount of this urobilinogen escapes into the general circulation and is excreted by the kidney where it is also oxidized to urobilin The greater portion of the urobilinogen is returned by the portal circulation to the liver and is re-excreted by that organ

Classification of Jaundice

- Obstructive jaundice 2. Nonobstructive jaundice
 - - (a) Hemolytic jaundice
 - (b) Toxic jaundice

Obstructive Jaundice - This is caused by an obstruction of the flow of bile through the common duct. This may be brought about by obstruction within the duct such as stones, para ates, plug of thick mucus, tumor, or inflamma tion of the duct It may be brought about by obstruction of the flow of bile by pressure upon the common duct by a tumor of a neighboring or gan, such as carcinoma of the head of the pan creas, and it may be brought about by atresia or congenital absence of the common duct which is sen in the newborn. For the purpose of illustration, let us place a stone in the common duct. No bile can pass this stone The normal amount of bilirubin present in the blood is being delivered to the liver and bile is being excreted by the liver cells, but none of it can escape into the duodenum and the bilirubin builds up in the blood stream and, therefore, we have jaundice

Nonobstructive Jaundice -(a) Hemolytic jaun dice is frequently a familial disease in which there is excessive destruction of red blood cells, causing the blood to deliver more bilirubin to the liver than that organ can handle and the excess is thrown back into the blood thus causing jaun dice however, there is no obstruction as in the There are a number of hemocondition above lytic agents, including the toxins of some bac ternal infection, such as malaria and septicemia, and the poisons of pernicious anemia and hemolytic disease such as arseniuretted hydrogen and dinitrophenol which will cause jaundice

(b) Toxic jaundice will show more extensive damage and depression of the secretory functions of the liver and is produced by heavy metals and other poisons, such as arephenamine chloroform, phosphorus, cinchophen trinitrotoluene, or the damage as seen in diabetic cirrhosis and cardiac cirrhosis Any of these may produce saundice and again there is no obstruction in the common duct

Functions of the Liver

It is now necessary to enumerate a few of the known functions of the liver

- Exerction of bilirubin
- Manufacture and secretion of bile
- Excretion of alkaline phosphatase
- Protein metabolism Deamination of amino acids and the regulation of the albuminglobulin ratio
- Storage of glycogen and regulation of blood sugar with the help of the pancreas and ad renals
- Production and storage of prothrombin and antianemic factor
- Synthesis of hippuric acid by conjugation of benzoic acid and glycine
 - Acetylization of the sulfonamides
 - Heparin production 9
 - Iron and copper storage 10
 - Reticuloendothelial activity (liver) 11
 - 12 Fat metabolism
- Heat production and storage of vitamin B
- 13 Formation of vitamin A from carotene

7.77

Detoxification and many more functions that are either vaguely known or unknown

Liver Function Tests

Tests for Storage Function of the Liver -The ability of the liver to store glycogen is tested by the levulose tolerance test in which the blood sugar curve is determined after the patient has taken 50 Gm of pure levulose dissolved in 250 cc The undamaged liver will store enough of the sugar to cause only a slight rise in the blood Under this heading there is the galactose tolerance test, in which the fasting patient is given 40 Gm of galactose in 500 cc of water This sugar is converted to glycogen with considerable difficulty Normally, 3 Gm or less are excreted in the urine within five hours, but if the liver is damaged and unable to convert the galactose to glycogen, the excretion in the urine rises to 4 or 5 Gm in the first five hours This test is of some value in obstructive jaundice, because the findings will be the same as in the normal liver, 1e, 3 Gm or less in the urine

Tests for the Excretory Functions of the Liver —

(a) Blood bilirubin will show if there is an ex cess of bilirubin in the blood

(b) Urobilin test of the urine, which is a simple office procedure, will show whether any bile is entering the duodenum where it is converted to urobilinogen, and later to urobilin

(c) Serum alkaline phosphatase estimation will show a backing up in the blood of phosphatase that should be excreted by the liver

(d) Protein metabolism as shown by the cephalin flocculation test

(c) Protein metabolism as shown by the serum protein and the albumin-globulin ratio (Normal serum protein 71 Gm per cent, Albumin 41 Gm per cent, globulin 2 7 Gm per cent, fibrinogen 027 Gm per cent, albumin-globulin ratio 151 Gm per cent)

(f) Increase in coagulation time due to lack of bile in the intestinal tract to activate vitamin K

(g) Van den Bergh test, direct and indirect

(h) Bromsulfalein and Rose-bengal tests are of value only if the bile ducts are clear

(1) Detoxification function test In this test 5 9 Gm benzoic acid is given by mouth specimens of urine for four hours are examined for hippuric acid A fairly efficient liver will excrete 3 to 31/2 Gm in four hours

(j) Formaldehyde gel test

Tests to Bc Used in Obstructive Jaundice -

(1) The first liver function test should be an examination of the urine for urobilin You will see from the diagram (Fig 1)1 that, if there is a complete obstruction of the common duct, no bile will enter the intestine, and, therefore, there

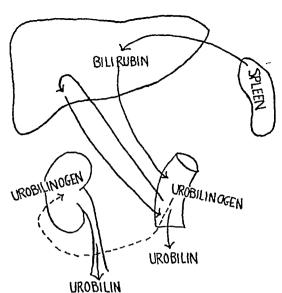


Diagram showing the formation of bilirubin from destroyed red blood cells in the spleen and the change of bilirubin to urobilinogen in the intestine, its exerction in part as urobilin in the feces and its absorption in part into the portal blood where it is re-excreted from the liver The dotted line represents the passage of urobilinogen from the intestine to the kidney, where it is excreted and oxidized to urobilin

will be no urobilin in the urine, if jaundice is a few days old

(2) Examination of the blood for bilirubin Serial examinations will show increase or decrease of jaundice

(3) Serum alkalıne phosphatase determina-Since the liver excretes this enzyme, the amount in the blood will increase greatly in obstructive isundice

(4) Hanger's cephalin flocculation test test, when done with fresh material, is very satisfactory and a positive test is against obstuctive jaundice

Any one of these tests may be positive in a patient with a normal liver function, but if two or three of them are comparably positive, you may be reasonably sure of liver damage. For example, if the serum alkaline phosphatase and cephalin flocculation tests are strongly positive, it is strong evidence in favor of altered liver function.

It also should be borne in mind that early in a case of simple obstructive jaundice the only findings will be increased serum bilirubin with slight jaundice, dark urine, and light-colored stools Due to blocking the flow of bile, the jaundice becomes deeper, the unne darker, the stools clay-colored, and the other liver function tests for obstructive nundice become positive If this obstruction is not relieved, the liver will be damaged and then the liver function test for both obstructive and nonobstructive jaundice will be nositive

Tests for Nonobstructive Jaundice —These are even less satisfactory than those for obstructive jaundice Lippincott et al gives an exhaustive report of liver function tests in soldiers with schistosomiasis japonica, under treatment with antimony compounds, "the initial studies of hepatic function showed the following incidence of abnormal results, globulin 5 per cent, formal dehyde gel 1 per cent. icterus index 4 per cent. serum bilirubin 6 per cent, urobilinogen 0 per cent, intravenous hippune acid 5 per cent galactose tolerance 4 per cent, bromsulfalein 12 per cent."2 It is, therefore, suggestive that minor liver damage can be detected best by the brom sulfalein test and serum bilirubin determination

Again the importance of the history and physical examination should be stressed A history of familial hemolytic jaundice or the taking of some drug will be much more valuable than the hver function tests.

Establishing the Cause of Jaundice

It is now time to consider a patient with jaundice and it is at this point that many an hour of valuable laboratory time is wasted on unnecessary and poorly chosen liver function tests Yone of the above liver function tests should be done until after an exhaustive history and com plete physical examination, including standard laboratory and x ray procedures have been done Your first interest in the jaundice is the question of obstruction and an exploratory laparotomy may be a life-saving procedure at this time, because what was supposedly a hopeless carcinoma of the head of the pancreas may turn out to be a stone in the common duct, or some other benign con dition. Please bear in mind that surgical intervention is not indicated in every case of jaundice and that the cases for surgery must be chosen

There is a tendency at present to excarefully plore nearly every case of jaundice and this is not a good procedure

The surgeon should view with suspicion the case he is about to operate that presents spider angiomata of the skin, pitting edoma, unex plained anemia, or hypoproteinemia rule applies to the jaundiced patient with tem perature awollen and tender liver, and, also, to the patient with a history of having had in the past four to eight months a transfusion of blood or plasma or a justory of having been vaccinated for small por

Conclusion

For treatment of a patient with joundice an exhaustive history, careful physical examination, rou tine inboratory and x-ray procedures, and surgical consultation all should be carefully studied in an attempt to arrive at a diagnosis. If the diag nous is not made, then the physician should decide what liver functions he wishes to test and then select two or three of the following liver function tests

- Examination of the urine for urobilin (office procedure)
 - Serum bilirubin
 - Serum protein and AG ratio
 - Serum alkaline phosphatase
 - Hanger's cephalin flocculation test 5
 - Galactose tolerance test
 - Bromsulfalein test

These tests are far from satisfactory and, until better procedures are evolved greater stress must be placed upon the history, physical examination. and other standard procedures

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STATE SOCIETIES URGED TO ACT ON HOSPITAL PROGRAM

One of the urgent problems brought up at the August meeting of the Joint Committee for the Coordination of Medical Activities is the need for all state medical societies to take an active part in the Hospital Survey and Construction Program. Dr Ernest Irona, chairman of the committee urges Dr. Ernest Irons, chairman of the committee ungesthat each state medical society find out the present status of the program and offer its assistance in seeing to it that funds are allocated where they can do the most good.

The program of this sat is to halo the states and

The purpose of this act is to help the states and

local communities build hospitals and establish health centers where they are most needed order to realize this purpose the committee believes it will be necessary for each state medical society to particulate actively in the state survey. The participate actively in the state survey. The Council on Medical Service plans to coordinate information on activities of the various state com mittees.

What is the status of the Hospital Survey and Construction Act in your state?—News Letter American Medical Association, October 23 1947

THE USE OF SODIUM NICOTINATE IN THE TREATMENT OF HEADACHE

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IN A RECENT article Goldzieher and Popkin reported considerable success in the treatment of various types of headaches by the intravenous injection of 100 mg of sodium nicotinate (Naotin) 1 They recommended the procedure for the "symptomatic treatment of (a) severe idiopathic headache, (b) migraine, and (c) postspinal tap cephalalgia "

The value of a successful, easily administered and harmless symptomatic therapy for severe headache is obvious, and, in an effort to confirm Goldzieher and Popkin's results, we have administered 100 mg of sodium nicotinate intravenously to 80 patients who were complaining of headache The results are summarized in Table 1 Goldzieher and Popkin secured complete relief of symptoms in 74 per cent of 57 patients classified of sodium nicotin ite is not of greater value than the intravenous injection of a small amount of Each of the 7 patients with sodium chloride migraine experienced symptomatic relief from the subcutaneous injection of dihydroergotamine (DHE-45) after the injection of sodium nicotinite had proved ineffective

Summary

The intravenous injection of 100 mg of sodium nicotinate produced no relief of pain in any of 7 patients during an acute migraine attack, and was no more effective in the symptomatic relief of patients with psychogenic or posttraumatic headache than was the intravenous injection of a small amount of a physiologic solution of sodium chloride

TABLE 1 -RESULTS OF TREATMENT BY THE INTRIVENOUS INJECTION OF SODIUM NICOTIVATE

Result of		its with ic Headache Per Cent		with Post- c Hendache Per Cent		ith Migraine	Miscellaneous Headache
Treatment Good result Fair result No benefit	15 6	40 15 45	10 5 20	30 15 55	Number 0 0	Per Cent 0 0	Number 0 1*
Total	38	100	35	100	$\frac{7}{7}$	100	1

^{*} Post malarial

by them as having "idiopathic headache" (they had only 2 patients with posttraumatic headache) and in all but one (90 per cent) of 9 patients with migraine, it is clear that this form of treatment was much more successful in their hands than in

For purposes of control Goldzieher and Popkin gave intravenous injections of 100 mg of nicotinamide to 13 patients with headaches (types unspecified) Only one patient reported definite We have treated 14 patients as a improvement control group by the intravenous injection of 10 cc of a physiologic solution of sodium chloride The results are summarized and compared with those obtained by the intravenous injection of sodium nicotinate in Tables 2 and 3 seem that for patients with posttraumatic or psychogenic headache the intravenous injection

TABLE 2 —COMPARISON OF THE RESULTS OBTAINED IN THE TREATMENT OF PATIENTS WITH PSYCHOGENIC HEADACHERS THE INTRAVENOUS INJECTION OF SODIUM NICOTINATE WITH I HOSE OBTAINED BY THE INTRAVENOUS INJECTION OF 10 CC OF A PHYSIOLOGIC SOLUTION OF SODIUM CHLORIDE

Treatment Used Sodium nicotinate Sodium chloride	Number of Patients 38 8	Percent- nge of Good Results 40 50	Percent- age of Fair Results 15 10	Percent age with No Benefit 45 40
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1 ABLC 3 — Comparison of the Results Obtained in the Treatment of Patients with Posttraumatic Headache by the Intravenous Injection of Sobium Nicotinate with Those Obtained in the Intravenous Injection of 10 Cc of a Physiologic Solution of Sodium Chloride

Treatment Used Sodium nicotinate Sodium chloride	Number of Patients 35	30	Percent- nge of Fair Results	Percent age with No Benefit 55 35
The 4 nations	. · · · ·	65	0	30

the 4 patients who benefited with NaCl had proviously benefited with sodium nicotinate

Reference

Goldzieher J W and Popkin G L JAMA 131 103 (1946)

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* Headache Chine Section Mental Hygiene Service Veterans Administration New York

THE CONSERVATIVE TREATMENT OF ECLAMPSIA WITH EMPHASIS ON THE STROGANOFF METHOD

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WHEN one considers the results obtained in the treatment of eclampsia today as compared with those obtained a generation ago, it is obvious from the various series reported that, while the results obtained are still far from ideal, there has been a very real improvement. In the absence of an exact knowledge of the cause of the disease, however, the treatment is still empiric

In the past the mode of procedure usually adopted in the treatment of ante- and intra partium celampsia was to effect immediate delivery no matter what the condition of the patient. This involved many major operative procedures from the old accouchement force to vaginal hysterotomy and abdominal cesarean section. The results were poor, with a general average numerical mortality of from 25 to 30 per cent. Unquestionably, many of these women died as a result of the treatment rather than from the discuss itself.

Case Reports

1—One of the most striking reports on the results of these old methods of treatment is that of Lichen stein from the Lepzig Clime in 1912.

In this series there were 400 cases of eclampsia with a gross maternal mortality of 18 5 per cent the mortality for the antepartum intrapartum, and post partum varieties being 28.5 12 6 and 27 14 per cent respectively Practically all of the antepartum and intrapartum cases were subjected to some form of operative delivery Analyzing the results Lichtenstein found that in general, the patients who did well were those who had lost considerable blood at the time of delivery and he felt that this blood loss was the chief therapeutic benefit derived from delivery Furthermore with the high mortality of 27 14 per cent in the postpartum cases he inquired why these results should be so poor if early delivery has any effect on the disease since in these cases one has the earliest possible delivery namely before the outbreak of the attack. As a result of his observa tions in this series, he became a strong advocate of venescetion as a mode of therapy and the adoption of this procedure was followed by prompt improvement in the results obtained

2—An impressive collection of cases was compiled by Plass in 1927: In this tabulation of reports by various authors he found that in 4 607 cases of oclampas treated by radical measures that is by immediate operative delivery the gross maternal mortality was 21 7 per cent whereas in 5 970 cases

Presented at the 141st Annual Meeting f the Medical Society of the State of New York, Buffalo Section on Obstatrics and Gynecology May 7 1947 by conservative therapy the maternal mortality was only 11 1 per cent

Since 1912 the tendency has been toward various methods of conservative therapy with a general improvement in the results obtained One of the oldest of these is the so-called Dublin method, essentially an active elimination mode of therapy. Others are directed toward control of convulsions by sedatives which affect the nervous system. Among them may be mentioned the Macpherson method involving frequent doses of morphia, the intravenous injection of magnesium sulfate as used by Lazard and the Stroganoff method

My own interest in the Stroganoff method was aroused by Stander's report after his vast to Stroganoff's Clinic in Moscow's Following Stander's report the method was adopted at the Johns Hopkins Hospital with improved results. Shortly afterwards in 1926 our clinic in Rochestre opened and I decided to treat 100 conservative cases by the Stroganoff method, in order to appring its value. After twenty years we still have not had 100 such cases but we have had a sufficient number to present for discussion.

Our celamptic material consists of 66 cases all treated by a modification of the Stroganoff method. These cases occurred in 20,940 deliveries an incidence of 1 in 317 deliveries.

As carried out by us the method is as follows

1 ON ADMISSION

- (a) The patient is placed in a darkened room and kept as quiet as possible preferably under the constant supervision of a special nurse. The patient should be kept warm.
- (b) The patient should lie on her side with the foot of the bed elevated in order to facilitate pharyngeal drainage.
- (c) Morphine 0 015 Cm (¹/4 grain), is given at once hypodermically unless the patient received a similar dose prior to admission
- (d) A catheterized specimen is obtained and sufficient blood is withdrawn by vena puncture for the necessary chemical studies
- (e) If not edematous the patient when conscious is allowed to drink water freely. If the patient cannot drink, 500 cc of 5 per cent glucose may be ad ministered introvenously.

- 2 One hour after admission 2 Gm of chloral hydrate in 100 cc of saline or milk is given rectally
- 3 Three hours later the 0 015 Gm of morphia (no more than 0 030 Gm in 24 hours) is repeated
- 4 Three hours later 2 Gm of chloral hydrate is given
- 5 Six hours later 1 5 Gm of chloral hydrate
- 6 Eight hours later 1 5 Gm of chloral hydrate

If the above procedure is followed, a total period of 21 hours elapses between the time of admission and the last administration of chloral By this time there should be good evidence of recovery if such is to be the result I would emphasize, however, that the above routine should not be meticulously followed, if a full course of therapy is not necessary Thus, several of our patients ceased having convulsions after the initial dose of morphia, while others responded after further medication but before the full course of therapy was completed If the patient's improvement warrants it, the treatment may be suspended at any point along the line of No attempt at delivery is made the routine until the cervix is fully dilated

In our series of 66 cases, there were 35 examples of antepartum eclampsia with six maternal deaths, a mortality for this group of 17 1 per cent, one a cardiac death, one due to cerebral hemorrhage, another to bronchopneumonia, while two died undelivered Operative procedures in this group included six low- and one midforceps operations. There were 18 fetal deaths, a mortality of 51 4 per cent, but of these only three were full-term babies. The other fifteen were either immature or markedly premature (all weighing less than 2300 Gm.)

Included in this antepartum group were 19 women, who under the Stroganoff treatment stopped having convulsions and improved markedly, but did not go into labor In these women labor was induced three days to two weeks later by some simple measure, such as medical induction with rupture of the membranes, or by introduction of a hydrostatic bag All of these women This group of so-called intercurrent eclampsia represents one of the important results obtained from conservative therapy tients improved markedly but not completely enough so that it seemed advisable to allow the pregnancy to continue However, the pregnancy could now be terminated at a more or less elective time by a simple and safe mode of procedure without resorting to a major operation

In our series there were 18 examples of intrapartum eclampsia. These were treated in a similar manner with treatment starting during labor as soon as the first convulsion occurred All eighteen patients recovered, but there were six fetal deaths, a mortality of 33 3 per cent. Three of these infants were premature. Operative procedures carried out in this group included ten low- and two midforceps operations, one version and extraction, one breech extraction, and one low cervical cesarean section. This latter is the only cesarean section in our entire series, and it was performed because of a contracted pelvis after a test of labor. Both mother and baby survived.

In the postpartum group there were 13 cases, all of which recovered One infant was born dead before the onset of convulsions as the result of a placenta previa The gross results are presented in Tables 1 and 2

TABLE 1 -MATERNAL MORTALITY

	Number	Maternal	Mortality
	of Cases	Deaths	Per Cent
Antepartum	35	0	17
Intrapartum	18	0	0
Postpartum	13	0	0
Total	66	6	9 9

TABLE 2 -FETAL MORTALITY

	Number of Infants	and	Born Dead or Died in 2 Weeks	Mortahty
Antepartum Intrapartum	35 18	17 12	18 6	51 4 33 3
Postpartum	One set of	12	ĭ	7
Total	67	41	25	37 3

Summary and Discussion

Sixty-six cases of eclampsia are presented, all treated by a modification of the Stroganoff method, with a gross maternal mortality of 99 per cent and a fetal and neonatal mortality of 37 3 per cent All the maternal deaths occurred in the antepartum group, possibly due to the fact that many of these patients were unregistered, had had no prenatal care, and came to the hospital only after the attack began Three of the six deaths were due to associated complications cardiac, cerebral, and pulmonary, which must be counted as eclamptic deaths The lack of maternal mortality in the intrapartum and postpartum groups is due, at least in part, to the fact that many of these patients had been admitted to the hospital on account of a preeclamptic toxemia and had had at least some therapy before the onset of convulsive seizures

The fetal mortality in eclampsia will probably always be high, since many of the infants are either very premature or even nonviable. No attempt has been made to subdivide our material into so-called mild or severe types. Criteria for

such differentiation vary widely and are, largely, the ideas of the particular individual. I prefer to regard all cases of eclamosia as representing a very serious situation, although, of course, some may be much more severe than others.

The results obtained in this series treated by the Stroganoff method are far superior to those formerly obtained by radical therapy and compare favorably with those obtained from other

methods of conservative therapy

The Dublin procedure the use of intravenous magnesium sulfate, and the Stroganoff method. all appear to give equally satisfactory results. It is not my purpose to advocate the Stroganoff method as being superior to the others, results obtained do not permit such a conclusion to be drawn. However, one important advantage of the Stroganoff method is its simplicity, it can be carried out in the home if circumstances make home treatment necessary

The important feature to emphasize is that results obtained from any of these conservative measures, empiric though the methods may be, are far superior to those obtained by the use of radical operative procedures. In my opinion major operative procedures, such as cesarean section, have no place in the treatment of eclampma unless there is some other complicating factor like mechanical obstruction which necessitates such a method of procedure

Conclusions

- Sixty-six cases of eclampsia treated by a modified Stroganoff method are presented with a gross maternal mortality of 9 9 per cent
- While there are other conservative methods available, this is to be regarded as a useful one until our knowledge of the disease permits the abandonment of all empire therapy
- The results obtained from any of the reliable conservative methods of therapy are far superior to those obtained by radical intervention Cesarean section and other major operative procedures have no place in the treatment of eclampsia unless associated factors are present which give indication of a need for such operative procedures. No attempt at delivery should be made until the cervix is fully dilated, when the operative procedure involved will be a sample one.
- 4. Finally, the prevention of eclampsia is just as or more important than the cure, and the great majority of cases can be prevented if proper prenatal supervision is carried out

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EVERYDAY LEVEL URGED FOR RELIGION

The trouble with most prayers and hymns is not that they are insuncere but that they are not at the level on which we are living, the Rev Dr Jonathan P. Evans, munister of the Vaucluse Congregational Church, Sydney Australia, declared in a recent sermen. sermon.

"Because people don't go about their work in a state of ecstasy it doesn't indicate a lack of re-

ligion, he said.

"We have times when we come into the presence."

The spirit of God but these moments come rarely The spirit

of religion is shown by the way you do your daily work, by being tolerant and courteous and by keeping a sense of humor
"We are apt to feel that since our life is without

emotional drive or semsation, that we've missed the real spirit of religion. That is why religion must meet us on a routine level, and if it can t meet us there, it is of no use to us. If it can t meet us on the mundane days of the week, it cer tainly can t meet us formally on Sunday "-A I

Times November 17, 1947

Of this number, 462,304 (653 per cent) received the group audiometer test, 8,755 of these were found sufficiently defective to receive otologic examinations, 3,291 were recommended for treatment after the examination, while 922 were recommended for special education In other words, the cities with a total school population of 288,650 recommended 748 pupils for special education. The villages, central schools, and union-free schools with 419,207 pupils in all recommended 174 pupils. for special education, or approximately one fourth as many as the cities

Of the 748 recommended for special education reported by cities, 912 per cent received special education. Of the village school districts, 92 pupils were recommended for special education and 414 per cent received special education. Of the 414 per cent received special education. Of the central school districts, 24 were recommended for special education and one third received it (Central school districts have approximately one half the school population of all the school districts and recommended 27 as against 748 by the cities) The union-free schools with 117,191 pupils registered. as compared with 285,560 in the city schools, recommended 55 pupils for special education. and 43 pupils received it

TABLE 1 - SPECIAL EDUCATION

Pupils Recommended	Pupils Receiving	Percentage
Cities 748	682	91 2
Villages 92 Central schools 27	38 9	41 4 83 8
Union free schools 55	43	78 2

The variation in these numbers may be accounted for by the fact that the cities are more apt to have classes and clinics for the hard of hearing children

At present, the facilities of the State for the hard of hearing children, exclusive of New York City Buffalo, and Rochester, consist of Conservation of Hearing Classes in four cities-Albany, Gloversville, Schenectady, and Syracuse State and is provided for the maintenance of these classes Tuition for nonresident students is set by the local school superintendent. In addition to these four classes, twenty-eight communities offer lip reading classes for hard of hearing children. All but six of these are located in the metropolitan area, Long Island, and Westchester County The remaining six are distributed throughout the state as follows Auburn, Binghamton, Ithaca, Olean, Utica, and Watertown

Statistics for 1944 to 1945 show one child in every 53 of the 462,304 children tested had a loss of 15 decibels or more, one child in every 140 required treatment, one child in 500 was recommended for special education, one out of every 607 received special education

The entire Catskill and Adirondack areas have no rehabilitation facilities whatsoever In fact, north of the Erie Canal, Watertown and Gloversville stand out as the only communities attempting to meet the needs of their hard of hearing children In the heavily populated southern tier of the State, including the Finger Lakes region, Olean, Auburn, Ithaca, and Binghamton have lip reading classes. The only conservation of hearing classes are in a line—Albany, Schenectady, Gloversville, and Syracuse. How can we meet the needs of the hard of hearing child throughout the State so that urban and rural children can have equal privileges?

Conservation of Hearing Clinics -In approved hospitals these serve to correlate and assist in the proper selection and classification of the hard of hearing children They direct the children along the proper lines of therapy and education to facilitate rehabilitation

Two types of educational services are needed

Conservation of hearing classes should be established in public schools with a full-time teacher giving instruction in lip reading, speech correction, training in residual hearing, training in the use of a hearing aid, and coaching in school subjects should be located in large cities and towns, spaced throughout the State in proportion to the school population from which they would draw sufficient pupils to maintain such a class

Lip reading and speech correction classes are needed in school districts where there are no conservation of hearing classes There should be one teacher certified to teach lip reading and speech correction daily to those less severely deafened in that school population which does not require attendance at a conservation of hearing class This teacher could be a regular teacher in another subject such as English. The teacher's schedule, as a matter of fact, could be varied depending on the number of children with impaired hearing

To carry out this program for the hard of hearing child, there is a need for teachers who will devote their entire time to conservation of hearing classes and for other teachers whose regular program will be modified to include lip reading and speech correction for those children less severely dealened It is the responsibility of the colleges and universities in New York State to offer training to meet the needs of these two groups

CORRECTION

In the article by Dr Eugene Davidoff, Sonyea, New York, entitled "Tridione Therapy in Institu-tionalized Epileptic Patients," which appeared in the July 1, 1947 issue of the New York State Journal of Medicine, an error occurs

Page 1492, column 2, paragraph 3
The sentence should read "After a careful preliminary physical examination, the patients were placed on 0.3 Gm. of tridione three times daily,"

instead of "3 Gm of tridione," as printed

SYNCHRONOUS COLON CARCINOMAS OF MULTICENTRIC ORIGIN

WILLIAM SHEINFELD, M D, Brooklyn, New York

(From the Prospect Heights Hospital)

IN ANY definitive operation for carcinoma of the colon or rectum a systematic search for possible metastases by preoperative atudies and exploration preceding the actual resection, is performed routinaly Palpation of the entire colon and rectum is equally important to note whether a second or even a third lesion is present. Abel' reported 2 cases of multiple carcinomas in 131 cases of colon and rectal carcinoma, Cockkinis 1 4 in 54 cases of colon car cinoma, Brindley 5 8 in 306 cases of large intestinal cardinoma, and Borson and Berger 16 in 344 patients with cancer of the large intestine. This makes a total of 30 cases of multiple lesions in 835 cases of carcinoma of the colon and rectum, or an aggregate incidence of 3.5 per cent. In addition, a number of other case reports of multiple colon carcinomas can be found in the literature. 4-7 The following case illustrates the clinical importance of bearing the possibility of multiple lesions in mind. In addition, varying morphologic degrees of malig nancy in the several lemons present are shown.

Case Report

MI J a white woman, aged 62, was admitted to the Prospect Helghts Hospital on Jahuary 13 1947 and discharged February 1, 1947 Nine months prior to her present admission she was operated upon for chronic cholecystitis and cholelithiass. A cholecystectomy and incidental appendectomy were performed. The eccum at that time was normal to palpation. She was well five months and then began suffering from recurring attacks of addominal cramps. These were relieved by medication at first but became increasingly severe and frequent up to the time of admission. They were most marked in the epigastrium and about the midabdomen. A barium enema given two weeds before hospitalization revealed an obstructing filling defect in the miditransverse colon (Fig. 1). This was laterpreted as an intrinsic neoplasm with a possible complicating intussusception. The right colon could not be visualized. Physical examination on admission revealed a white woman of 62 in good general health not acutely ill, with negative findings. On abdominal examination the scar of the previous operation was noted. No other abnormalities could be found.

Laboratory Data —The white blood count was 7100 cells, with 49 per cent polymorphonuclears 46 per cent lymphocytes, 4 monocytes, 1 cosinophil red blood cells 3,840,000 with hemoglobin 72 per cent, total protein 5 74 Gm. per cent albumin 3,99 Gm. per cent, globulin 1 53 Gm. per cent A/G ratio 2,0 1 Blood sugar was 95.2 mg. per cent urea 7.8 mg. per cent urea and chlorides 600 mg. per cent The urine was normal.

The patient was prepared for operation. Eightem grams of sulfasuxidine were given daily for six days. A low residue diet daily enemas, and colonic irrigations were given for several days before operation.



Fig. 1 Barium enems showing large filling defect in transverse colon. Some barium has passed beyond the lesion

On January 16 1947 exploration was done through a right rectus incision (W S) The mass in the transverse colon was a partial intussusception readily reduced. A soft large polypoid mass almost completely occluding the lumen was then felt. The entire large intestine was pelpeted. A hard mass involving the occum was noted. This had the typical appearance of carcinoma and was a surprise finding. The descending colon and rectum were normal. There was no evidence of glandular, hepatic, or peritoneal metastases. The terminal lieum, right colon and most of the transverse colon were resected. The splenic flexure was mobilized and brought down. The open end of the large intestine was inverted, closed and an open end-to-side lieocolostomy performed. The greater omentum was removed with the transverse colon. A complementary valvular ileostomy was made the catheater being brought out through a stab wound to the left of the incision.

With the exception of some evidence of peritoneal infection or irritation present from the fourth to seventh postoperative days and then subsiding, convalescence was uneventful. The wound healed by primary intention and the fleostomy closed twenty four hours after the catheter was withdrawn.

Report of Pathologist.—The gross and microscopic pathology are described by Dr Sillik Polayes. The specimen includes 15 cm. of distal ileum and



Fig 2 Gross specimen showing the malignant ulcer at the ileocecal junction (large arrow) and large polypoid mass (small arrow) in transverse colon. The small polyp has been removed for sectioning hence it is not present in the specimen. Note the complex mass of multiple polyps constituting the main polypoid mass. It appears grossly malignant. Microscopically, however, only incipient malignant changes are demonstrable. See Fig. 5.



Fig 3 Section through the malignant ulcer at the deoceeal junction showing malignant glands (B), arising in and decreating through the mucosa (A) The malignant glands have penetrated the

about 40 cm of colon (Fig 2) About 3 cm. from the ileocecal junction there is a malignant ulcerative mass in the cecum almost completely annular. The edges are raised firm and red. At the base of the ulcer the lesion infiltrates the entire wall of the cecum. About 1 cm. distal to the ulcer, a polyp, 1 cm. in length, hangs from the mucosa by a narrow pedicle. About 11 cm. from the distal end of the resected gut there is a sessile blue-red papillary growth about 7 cm. in greatest dimension. It protrudes into the lumen and causes partial intussusception of the proximal colon into the distal. The polypoid mass is well demarcated from the adjacent edematous mucosa and does not show involvement of the wall

The pertinent histologic features are given in the

legends describing the illustrations

Diagnosis —Adenocarcinoma of cecum, incipient malignancy of polyp in transverse colon, polyp of cecum.

Summary and Conclusion

- 1 Multiple colonic lesions appear in an appreciable percentage of cases and always should be looked for
- 2 Adequate therapy consists of radial surgery suitably applied to the problem at hand.
 - 3 A case is presented illustrating these points
- 4 The microscopic pathology of the several lesions encountered in this case demonstrates his-



Fig 4 Section through the large polypoid mass in the transverse colon showing one pedicle (A) of the complex structure of multiple polyps constituting the mass. Note that there is no epithelial invasion of the pedicle (A) or of the well of the colon

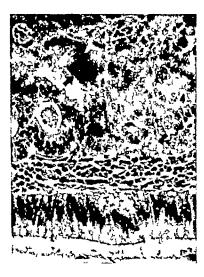
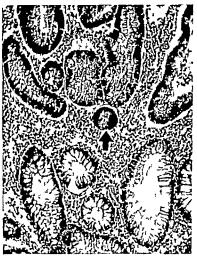


Fig 5 Higher magnification of a section from Fig. 4 showing atypism (large arrow) and heaping up (small arrow) of the epithelial cells lining some of the polyps (460 ×)

tologic changes of simple benign deviation from the normal, early malignancy, and advanced fully developed adenocarcinoma.



Pia 6 Section through the small polyp in occum near the malignant ulcer showing relatively normal epithelial lining. Loss of secretory activity of the cells with associated hyperchromatic staining of the latter (arrow) are the only abnormal changes noted (375 X)

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CHEST PHYSICIANS TO MEET

The New York State Chapter of the American Congress of Chest Physicians will hold a selectific meeting at the Hotel New Yorker New York City, on January 29 1948. In addition to morning and

afternoon scientific sessions a banquet will be held in the evening.

All members of the medical profession interested in chest diseases are welcome.

Nors: I wish to thank Dr Silik Polayes for his kindness in selecting the sections for illustration, in marking the photographs, and writing the legands of Figs. 2 to 6.

UNTOWARD SIDE-EFFECT FOLLOWING BENADRYL ADMINISTRATION

HARRY SWARTZ, M D, New York City

SINCE March, 1946, when benadryl (beta-dimethylaminoethyl benzhydryl ether hydrochloride) became available to the medical profession, many undesirable effects following its usage have been reported. These effects vary in intensity and duration involving one or a combination of many systems, or are localized to a particular anatomic area. For the most part, these effects have been attributed to the toxic action of the drug

Recently, however, several instances of quite paradoxical side-reactions have been recorded in the literature Benadryl, given because of its potent antihistaminic action for the relief of allergic manifestations, has been noted to precipitate such mani-Waldbott reports three instances of festations spontaneous asthma after the administration of this drug,1 Friedlander and Feinberg report a case of vasospasm of the fingers of one hand following benadryl,2 exacerbation of symptoms for which the drug was given is reported by Levin.3 Although no definitive investigations were made in these cases and, therefore, the manifestations arising after ingestion of benadryl might have been coincidental, it is most probable that they were specific allergic responses induced by hypersensitivity to the drug

Among the allergic symptom-complexes for which benadryl has been recommended and used is Ménière's disease. On the other hand, dizziness, nausea, and vomiting have been reported singly or in combination but always more or less transient in nature, as common side-effects of the drug. As far as can be determined, the literature does not describe an instance of true Mémère's disease as a benadryl side-effect. For this reason, the following case is reported.

Report of a Case

A 32-year-old white man with a thirteen-year history of sneezing, rhinorrhea, lacrimation, and itching of nose and eyes, beginning in the middle of May and lasting until October, had been treated for the past four seasons with excellent results. The treatment consisted of hyposensitization with timothy and ragweed pollen. Because, in the last year, symptoms began to extend perennially in mild degree, he was given the full complement of intradermal tests, found sensitive to multiple foods and inhalants in addition to his pollen sensitivity and, therefore, was placed on dietary and environmental control. He was placed on perennial therapy, dust hyposensitization being included in this regimen.

He was entirely free of symptoms until February, 1946, at which time his work necessitated his leaving the city. He was instructed to maintain treatment while away and was not seen again until June 8, 1946. At this time, he presented himself with full-blown symptoms of summer hay fever and the story that he had neglected to continue hyposensitization as instructed. Complete physical examination revealed a well-developed, white man with markedly boggy, pale, nasal mucosa, mild posterior pharyngeal wall edema, and bilateral conjunctival injection. Occasional, transient sibilant rales were heard

over both lung fields Blood pressure was 118/70 No other physical abnormalities were noted

Because there had been a four-month lapse since his last injection of pollen extract and because he presented himself during the height of the grass pollen season, it was decided to treat him symptomatically for the remainder of the season. Fifty-milligram benadryl "kapseals" were prescribed for him and he was instructed to take one that evening and to repeat at six-hour intervals if necessary. He was made to understand that the dosage varied with the individual case and that it would be best for him to take as few "kapseals" as possible to control his symptoms

At this Three days later, he was seen again time, he reported that his symptoms had entirely disappeared and that he had maintained himself in this symptom-free state on two "Lapseals" per day, one on arising and one in the late evening. His only complaint was a feeling of fatigue and weakness Physical examination on this day revealed a modern of the state of the sta ate, facial pallor, clear conjunctivae, marked reduction in nasal mucosal swelling, and a clear pharynx No abnormal physical signs were noted in the lung Blood pressure had fallen to 108/64 on refields peated readings He was elated at the success of the treatment but complained about the ease of fatigue and the fact that his eyes would stay open only with However, he continued about his business. He was asked to carry on his present regimen and to report back in three days

On the morning of the sixth day after inception of treatment (June 14, 1946), he was seen in his home in response to an emergency call from his wife. By this time, he had had a total dosage of 550 mg of benadryl. The only side-effects to date had been ease of fatigue and sleepiness.

The night before, he had taken a "kapseal" and gone to bed Early in the morning, he had awakened drenched in a cold sweat On opening his eyes, he had experienced an intense sensation of rotation around the long axis of his body, had become nauseated, and vomited He shut his eyes quickly and lay still Nausea and vertigo remained but vomiting abated Any motion or attempt to open his eyes resulted in intensification of the sense of rotation and vomiting In addition, he complained of a bilateral ringing in the ears that was constant and humming in quality Examination revealed a pale, only mildly edematous nasal mucosa, conjunctivae and pharyngeal wall were clear. There was a marked, rapid lateral nystagmus, cold clammy skin wet with perspiration, and generalized pallor Blood pressure had fallen to 90/60 on repeated readings and any attempts to change his position in bed met with retching and complaint of increasing ver-A diagnosis of acute labyrinthitis was made, benadryl was stopped and he was given an injection of ephedrine, 3/8 grain, and told to take the same dosage by mouth every two hours

The next morning the symptoms had abated only slightly He was still confined to bed, unable to move, opening his eyes only with the greatest caution Tinnitus, vertigo, and nystagmus were still present He was placed on a high protein, high potassium, salt-free, fluid restricted diet Ephedrine was stopped and 9 Gm. of ammonium chloride daily

was prescribed

On the third morning of labyrinthme symptoms, he was able to rise from bed and sit in a chair Now, however he dared not lie down since such change in position precipitated the entire complex of symptoms. Vertigo was not as marked, the nystagmus was still present but at a slower rate and he still complained of tinnitus. Blood pressure remained at 90/60 and pallor was beginning to

When on the sixth morning symptoms still main tained at this level it was decided to give him one more day of trial on the anticdema regimen and, then, perhaps attempt a spinal tap. He was seen on June 21 1946 seven days after inception of symptoms and cossation of benadryl There had been a moderate improvement in the past twenty four hours. He was able to walk about for a few moments without support. Nystagmus was gone almost entirely and the tinnitus had disappeared Spinal tap was not performed

Three days later June 24 1946, he returned to Labyrinthine symptoms had completely work. Now however, his hay fever came on in full measure and the allergic inflammation of the nose pharynx and conjunctivae reappeared. His blood pressure returned to 118/70 For about a week he was maintained with moderate symptoms by local therapy a nasal filter and vasoconstrictors by mouth.

On July 1 1046 however, he was desparate enough to agree to a trial of benadryl once more This time 20 mg. of the clixir (two tenspoonfuls) were given him on an empty stomach Within thirty minutes his nasal and conjunctival symp-Within toms abated his face became pallid and he vomited nausea, vertigo and tinnitus returned. His blood pressure fell to 00/60 He was placed on a cot and 0.8 cc. of adrenalin was administered every half hour for the next two hours. For the next four hours symptoms continued, gradually abating. Shaken but symptom-free he went home

Having gone this far he was prevailed upon to take benadryl a third and last time On July 28, 1946, during the free period between the grass and weed pollen seasons he was given approximately half the contents of a benadryl "kapseal in half a class of water Once more within thirty to forty minutes, labyrinthine symptoms appeared and followed a course entirely similar to that resulting from the elixir The total duration of symptoms this time was eight hours adrenalin again being

used in attempt to control them sooner

Comment

Before his experience with benadryl, this patient had never suffered from Ménière's disease or any symptoms that resembled it. Vertigo tinnitus, and nystagmus were strangers to him. Nausea and vomiting he had known as the result of occasional alcoholic or dietary indiscretions. His family history was entirely negative for this condition. There was no history of middle ear infection nor custachian tube involvement at any time. He had been in per fect health except for summer and fall hay fever for the past thirteen years, and mild perennial allergic coryga for the past year Followed to date there has been no recurrence of labyrinthme symptoms in any degree.

He was an atopic individual and showed multiple ingestant and inhalant sensitivity by skin test. Because of this and because he showed both cow hair and beef sensitivity it was suspected that the first onset of Ménière s disease might be due to the gela tin of the 'kapscals. (Gelatin is most commonly made from cow, lamb and hog hides) However this was clinically unlikely because he had taken gelatin in capsule form in the past and had suffered no ill effects. To rule out this possible allergen, the elixir was tried. When symptoms appeared follow ing the elixir it was realized that they might be on a basis of sensitivity to contents of the clixir and not the benadryl On this basis, the powdered benadryl of the "kapseal' was given the patient. When he reacted to this with the same symptoms, it was clinically evident that it was the benadryl itself which initiated the symptoms.

Although no definitive studies were made here such as direct skin test and passive transfer with the drug, it seems highly probable that the acute laby rinthine symptoms severe prolonged, and incapacitating, were due to hypersensitivity to benedryl itself

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Mayo Cln. 18: 45 (1945)

W.H.O FELLOWSHIPS FOR 1947 AWARDED

The Headquarters Office of the World Health Organization reported recently that 192 fellowships for the year 1947 have been awarded. Virtually all branches of medicine and public health are represented among the doctors and other health specialists selected to study at world centers under a \$1 500 000 grant from funds of the United Nations Relief and Rehabilitation Administration for field services.

An additional 200 fellows will continue this work under another grant for 1948.

Among the 1947 fellows, Poland is sending 54, China 42, and Yugoslavia 35.

SEVERE ANEMIA IN A CASE OF DIAPHRAGMATIC HERNIA

Aaron Cohen, M D, Wilfred Dorfman, M D, and Samuel Epstein, M D, Brooklyn, New York

(From the Medical Services of Dr Thomas J. Longo, Medical Director, Coney Island Hospital)

AMAN, P C, aged 64, was admitted to the medical service of the Coney Island Hospital on March 25, 1944, and was discharged on May 5, 1944. His chief complaint on admission was shortness of breath. The present illness began fifteen days before admission when he was seized with shortness of breath while climbing stairs. Thereafter, he noticed shortness of breath on moderate exertion. This seemed to be associated with indigestion.

His past history was essentially negative. There was no history of bleeding from the gastrointestinal tract, and no tarry stools. Physical examination revealed a marked pallor. His tongue showed no glossitis nor signs of abnormal smoothness. A loud, blowing systolic murmur was present at the apex. There was no evidence of cardiac enlarge-

ment The liver edge was palpable two fingers breadth below the right costal margin. His extremities showed a slight pitting edema bilaterally

Laboratory study showed a blood count of 3,150,000 with a hemoglobin of 46 per cent, the white blood count was normal. The Wassermann test was negative The stool was repeatedly negative for occult blood ova, and parasites. The gastric analysis showed normal values for free and total acidity. The urine was repeatedly negative and blood chemistry figures were within normal range. The electrocardiogram showed a slight, left axis deviation. A teleoroentgenographic study of the heart showed slight, left ventricular prominence, elongation of the aorta, and minimal pulmonary congestion. A gastrointestinal series reported moderate hermation of the cardiac end of the stomach through the esophageal orifice. The gastric tone was good, and the duodenum and small intestine were normal. In six hours the stomach was empty. A barium enema examination was

also normal Gastroscopy revealed an area at the lower end of the esophagus that was similar to a sphincter in its action. With each inspiration a marked constriction would occur, and relaxation would follow with expiration. As the patient adjusted to the manipulation of the instrument, the rapidity of this sphincteric-like action diminished. No local hemorrhages, ulcerations, nor congestion were observed.

The patient was placed on iron therapy with prompt hematologic response. He left the hospital and was advised to cut down on his physical work, so that the sphincteric-like action of the diaphram would be curtailed. Three to four months later he showed no anemia, with no new findings

Comment

This case is reported because no obvious reason for the anemia in highest hernia was evident. There was no achlorhy dria, no gross bleeding, nor evidence of a gastrointestinal lesion such as a peptic ulcer or malignancy to account for the anemia. There was no evidence of severe dietary deficiency, either in the history or in the physical examination anemia could not be accounted for by any impairment in digestion, such as would be present in dysentery, sprue, pellagra, or idiopathic steatorrhea There was also no evidence of hookworm infestation or Bothriocephalus latus, both of which can cause hypochromic anemia. It is possible, however, that the anemia can be explained in this instance by the nonabsorption of iron, since the function of the stomach in converting ferric iron to ferrous may be ın disorder At any rate, the addition of ferrous iron quickly relieves the anemic state.

CORRECTION

In the October 15, 1947, issue of the Journal, in an article on "Chronic Osteomyelitis in War Wounded A Report of Two Veterans Discharged with Intractable Osteomyelitis and Successfully Treated with Local Penicillin-Detergent Therapy," an error occurs on page 2205, in the last paragraph. The word "saucerization" should be substituted

for the word "cauterization" in the final sentence. The sentence correctly reads "It appears possible that the mutilating treatment of osteomyelitis by radical surgery and saucerization is outmoded and should be replaced by conservative procedures employing antibiotics, as in the method described in this report"

VOMITING FROM MULTIPLE CAUSES

BERNARD A. DUTFT M.D., Albany New York

(From the Gymecological Department of St. Peter's Hospital)

THERE is no mystery about the physiologic mechanism of vomiting It is well known that the act of vomiting is controlled by a center in the medulla and that this center is supplied by afferent impulses which may arise from any region of the body

Not slways so clearly understood, however are the precipitating causes, and the temptation to attribute uncontrolled vomiting to psychic or psychosomatic factors when a diagnosis is not readily apparent may prove too strong for the unwary It is for this reason that the present case is offered

Case Report

A 80-year-old married white woman of one-child sterility was seen in her home on December 8 1946, with a chief complaint of nausca vomiting, and generalized lower abdominal pain of two days duration. The condition was characterized by a sudden onset and by associated chills and fever The patient was in visible distress There were no

previous episodes

Significant findings of the initial examination were Temperature 103 F pulse 110 there was right there was right costovertebral tenderness, the abdomen showed right and last lower-quadrant tenderness. In the pelvic region there was marked bladder tenderness especially in the area of the trigone the cervix was bilaterally lacerated, the uterus was retroflexed, fixed in position and tender to all movement, and the admin were tender and palpable bilaterally. There was no abdominal distention palpation of the gallbladder was negative the uterus was of normal sue, and no significant enlargement of either adnexa could be felt.

The patient was admitted to the hospital the same day with tentative diagnosis of recurrent pelvic inflammatory disease and was treated with continuous Wangensteen suction, intravenous glucose, intravenous sulfadiazine and parenteral penicillin 100,000 units followed by 50,000 every three hours. Laboratory findings at this time were white blood cells 10,250 with 90 per cent polymorphonuclears, hemoglobin 77 per cent catheterized specimen of pur urine showed many red blood cells clumps of pur health are harm Zondek cells, and coarse granular casts Aschheim-Zondek test was negative gallbladder and gastrointestinal series were both negative.

Notwithstanding several remissions the patient improved gradually over a ten-day period, at the conclusion of which pelvic examination revealed a decrease in the bladder tenderness but persistent bilateral adnexal tenderness with a soft adherent mass on the left side, this mass was felt to be approxi-mately 8 cm. in its long axis.

Fourteen days after admission the patient was given a barium enema the x-ray findings were negative. Nevertheless, the patient again became nauseated and she vomited intermittently during the next four days. In the week following she im proved gradually and a polvic examination was repeated with findings which did not differ from those last described Accordingly a diagnosis of recurrent pelvic inflammatory disease with left tube-ovarian abscess was made and the patient was prepared for operation.

On January 2 a panhystero-left-salpingo-ovari-tomy was performed. The following facts were ectomy was performed revealed at operation The appendix had been removed in a previous operation. The uterus was slightly enlarged retroflexed, and adherent with numerous adhesions. The right tube presented evidence of mild salpinigitis and it was nonpatent the right overy showed no pathology The left tube was swollen and engorged and was firmly adherent by its imbriated end to the left ovary, the left ovary which measured 6.5 cm. in its long axis, appeared to be normal, although both tube and ovary were firmly adherent to the lateral pelvic wall,

Postoperatively the patient did very well, she was out of bed on the third day On the fifth day how over she again become nausented and began to vomit Examination now showed that her temperature was 08 F pulse 100 marked bladder tenderness and generalized tendernoss in the cul-de-sac with some brawny induration (a not infrequent finding follow-ing panhysteroctomy) A specimen of cathoterized urine contained clumps of pus cells and many red

blood cells.

Treatment at this point consisted of intravenous fluids Wangensteen suction streptomycin, and supportive measures. There was a gradual decline in the patient s general physical condition during the next ten days. Then, on the night of January 17 fifteen days after operation, while the patient was sleeping there was a considerable amount of serosanguinous vaginal discharge Pelvic examination revealed a rough friable, cauliflower-like area approximately 4 cm. in diameter in the left posterior fornix. A diagnosis of hematoma formation with necrous of the vaginal cuff was made.

The discharge disappeared gradually and the patient improved forthwith She was discharged from the hospital on the seventeenth postoperative

day

Summacy

A case of uncontrollable vomiting due to polvic pritation by several different agents is presented. The agents were (1) recurrent acute pelvic inflammatory disease (2) barium enema (3) poetoperative hematoms with necrosis of the vaginal

The author believes the causation of vomiting is reflex in nature, in the present case due primarily to pelvic irritation associated with a lowered threahold in the vomiting center

836 NEW SCOTLAND AVENUE

MEDICAL NEWS

Program Planned for Research in Leprosy Treatment

HE Advisory Medical Board of the Leonard Wood Memorial and a group of consulting chemotherapists, nominated by the chairman of the Medical Board of the National Research Council, recently met in New York City for the purpose of planning a program for extensive research to find improved drugs or methods for treating leprosy

The meeting was probably the first at which a

large group of scientists, most of whom were not leprologists, has met to consider this health problem

from the strictly scientific viewpoint.

There was general approval of two plans establish a cooperative scheme with selected workers in various countries, under a central coordinating committee, whereby the new drugs now in use may be valued scientifically by uniform methods of procedure and recording Another is to establish, in connection with some suitable leprosy institution, a testing unit with special personnel to make preliminary tests of new drugs which appear to be of promise but which have not yet been used in the treatment of leprosy

Top Industrial Medical Authorities Named for NYU Board

PLANS for the operation of the recently maugurated Institute of Industrial Medicine of the Department of Preventive Medicine, New York University-Bellevue Medical Center, were furthered recently with the announcement that ten of the nation's top-ranking authorities in the field of industrial medicine have been named to its Medical

Advisory Committee
Dean Currier McEwen, of the New York University College of Medicine, announced that the following leaders had accepted appointments. Dr. J. M. Carlisle, medical director of Merck and Company Dr A. G Cranch, director, industrial toxicological department, Union Carbide and Carbon Corporation, Dr David H. Goldstein, medical director, New York Trines, Dr Willard Machle, New York industrial consultant, Dr M N Newquist, medical director, the Texas Company, Dr Robert Collier Page, general medical director, Standard

Oil Company (New Jersey), Dr Kenneth Peacock, chairman of the committee on industrial medicine of the New York County Medical Society, Dr Leo S Price, medical director, Union Health Center, Dr J J Wittmer, assistant vice-president, Con-solidated Edison Company, Inc, and W P Yant, vice-president in charge of research, Mine Safety

Appliance Company, Pittsburgh, Pennsylvania Dr Henry E Meleney, Hermann M Biggs professor of preventive medicine, New York University College of Medicine, is also a member of the committee, whose chairman is Dr Anthony J Lanza, director of the Institute The Institute was officially inaugurated last June as an integral part of the planned Medical Center Dean McEwen characterized the formation of the committee as another step in "assuring American industry that the new Institute will be dedicated to better health for more workers"

Diagnostic Units Set Up for New York City

FACILITIES for the diagnosis of virus and rickett-sial diseases are being organized for the Health Department by the Public Health Research Institute of the City of New York, Inc, it was announced in the annual report of the research in-

stitute by David M Heyman, president

Laboratories to diagnose virus diseases, which include a host of the most distressing modern ailments, have long been needed in the city, but their establishment has been delayed because of lack of facilities and trained personnel Dr George K. Hirst, chief of the division of infectious diseases of the institute, is now organizing and supervising the activities of the new laboratory service, and he will set the standards for adequate performance of tests, Mr Heyman added

The importance of the virus disease diagnostic service is indicated, the report said, by the fact that during the smallpox epidemic in April the institute was able to grow smallpox virus in chick embryos and thus confirmed the diagnosis of the disease in two or three days This was the first time the city had this service readily available

The research institute made further progress during the year in the development of a practicable method for evaluating the nutritive status of population groups by the use of what is called the "microchemical" method of analysis In a survey supported by the New York State Joint Legislative Committee on Nutrition, the feasibility of the "microchemical" method of analysis on a large group was demonstrated This survey showed that in one high school in the city 30 per cent of the girls had hemoglobin levels distinctly below those of a well-nourished group, he added
The Public Health Research Institute of the City

of New York, Inc, was established under Mayor Fiorello H. La Guardia in 1942 as a nonprofit corporation, to which the city contributes \$100,000

annually

Chronic Disease Program Outlined

MEETING in Chicago recently representatives for national welfare and modical groups recommended a program for aiding the 25,000,000 Americans who are reported to have chronic diseases. Sponsors of the program are the American Medical Association the American Public Welfare Association, the American Hospital Association and the American Public Health Association

The organizations said that of those persons with chronic diseases some 7 000 000 were partly or completely incapacitated and each year nearly

1 000 000 died from such illnesses.

The groups recommended the following program for all states and cities to broaden and coordinate

with Federal help

 Prevention Intensified health department programs to control chronic communicable diseases are called for Accident provention programs and health education of all kinds should be greatly expended."

- 2 Medical care "There is need for a new program which places major emphasis on the early stages of chronic illness. This requires construction of hospital and laboratory facilities to cover all our communities."
- Rehabilitation "Occupational retraining and job placement are essential therapeutic and preventive measures
- 4 Research 'Further advances in provention as well as treatment of many chronic diseases depend on research "

The association said that in eight states and four cities action to meet the problem "already has been taken or is in the planning stage." The states are California, Connecticut Illinois, Indiana, Maryland, Massachusetts, New Jersey, and New York. Cities listed were Chicago Cleveland, Milwaukee, and New York.

MEETINGS

PAST

American College of Physicians, Western New York Region

Dr Hugh J Morgan, Nashville Tennessee, president of the American College of Physicians, spoke at the regional meeting of Western New York members on October 23 at the Onondaga Country

Club Syracuse.

Speakers at the morning and afternoon sessions included Dr Herbert R. Brown, Rochester, Dr Allan D Bass, Syracuse, Dr Simon Propp Albany, Dr George H. Relienstein Syracuse Dr Eugene L. Louner Syracuse Dr Charles G Craddock, Jr. Rochester, Dr Roger 8 Mitchell, Trudeau, Dr James Monroe Ray Brook Dr Richard H Lyons Syracuse Dr John N Hayes, Saranac Lake Dr Paul Bunn, Syracuse University Dr John H. Talbot, Buffalo Dr J. Howard Forguson, Syracuse Dr George M. Mackensie Albany and Dr Ronald L. Hamilton, Binghamton.

New York Council of Surgeons

Two loctures were held recently at the Parkcharter General Hospital, New York City, sponsored by the New York Council of Surgeons. On November 25 Dr Lester J Unger director of the blood and plasma division of New York Post-Graduato Medical School and Hospital, disoussed "Recent Advances in the Rh Factor and Its Practical Application," and on December 2, Dr Henry Mates associate surgeon at Harlom Eye and Ear Hospital, spoke on "The Diagnosis and Treatment of Eye Diseases of Interest to the General Practitions."

Saranac Lake Medical Society

Dr A J Vorwald spoke on "Medical Problems Concerning Industrial Uses of Beryllium at a mosting of the Saranac Lake Medical Society held on December 3 at the Saranac Laboratory

Eastern New York Eye Ear Nose and Throat Association

Members of the association were guest speakers at the scientific session of the Eastern New York Eye, Ear Nose and Throat Association, held on December 3 at the University Club Albany Drohn A. Cetner presented a paper on "The Newer Implants Employed in Enucleation, and Dr Benjamin M Volk gave a 'Discussion of Ludwig's Angina.'

FUTURE

Council on Medical Service American Medical Association

The Midwest Regional Conference of the Council can Medical Service of the A.M.A. will be held January 4 at Cleveland, Ohio, prior to the opening of the interim section of the A.M.A.

National Conference of County Medical Society Officers

The Grass Roots Conference of the National Conference of County Medical Society Officers will

be hold January 6 at Cleveland, Ohio with a stated purpose to develop a working partnership between the A.M A. and every physician.

Subjects to be discussed include "The General Practitioner—How to Create More of Him for the Future Need of the Country' Upholding the Prestige of the General Practitioner, and "The General Practitioner and Community Leadership

Mount Sinal Hospital

A series of lectures on "Recent Advances in Surgery" is being held on Wednesday evenings at

Mount Sinai Hospital, New York City, to which all interested are invited

Future sessions, with lecturers and their subjects.

January 7—Dr G Glen Spurling, clinical professor of surgery, University of Louisville, School of Medicine, Louisville, Kentucky, "Lumbar Intervertebral Disk Lesions", January 21—Dr Oliver Cope, assistant professor of surgery, Department of Surgery, Harvard Medical School, Boston, Massa-chusetts, "The Treatment of Hyperthyroidism in Transition from Surgical to Medical", February 11
—Drs James W Watts and Walter Freeman,
George Washington University, Washington, D.C., "Pain and Disability'

March 3—Dr Charles B Huggins, professor of urological surgery, University of Chicago, Chicago, Illinois, "The Diagnosis of Disease by Enzymatic Methods", March 17—Dr Robert Elman, associate professor of surgery, Washington University, St Louis, Missouri, "Protein Needs in Surgery", April 7—Dr Allen O Whipple, professor of surgery, Columbia University, April 21—Dr Robert E

Gross, Children's Hospital, Boston, Massachusetts. "Surgery in the Early Months of Lafe"

Postgraduate medical courses to be conducted at Mount Sinai Hospital in 1948 have been announced. These include a Symposium in Medicine, from February 2 to April 3, in cardiovascular diseases, gastrointestinal diseases, diseases of the liver, kidney, chest, allergy, diseases of metabolism, endocrinological diseases, venereal and skin diseases, and hematology

Individual courses, varying in length, from January 5 to May 22, will be given in elementary and advanced electrocardiography, genatures, gynecology, bedside clinics in heart diseases, recent advances in neurology and psychiatry, psychiatry in general medicine, surgical pathology, clinical pediatrics, physiology, surgery of the gastrointestinal tract, and symposium in ophthalmology

For further information address the Registrar for Medical Instruction, Mount Sinai Hospital, Fifth Avenue and 100th Street, New York 29, New York.

PERSONALITIES

Honored.—Dr Raymond S Megibow, of Mount Sinai Hospital, Dr Doris J W Escher, Montefiore Hospital, and Dr Roslyn Wiener, New York Hospital, who were awarded the three fellowships granted by the Rosenstock Memorial Foundation, Inc., Long Island City, a philanthropic foundation for the purpose of fostering individual medical research without regard to race, color, creed, or sex.

Appointed.—Dr Donald A. Covalt, former chief, Veterans Administration Physical Medicine Rehabilitation Service, as associate professor of physical medicine and rehabilitation at the New York University School of Medicine and head of the University's new Rehabilitation Institute A. Ray Dawson, former head of the physical medicine rehabilitation service in the Richmond, Virginia, branch office, to succeed Dr Covalt Dr Harry S Mustard, as New York City Health Commissioner, replacing Dr Israel Weinstein, resigned Dr William F White, Buffalo, formerly acting surgeon for the Buffalo Fire Department, as head of the list for surgeon approved by the Civil Service Commission

Elected -Dr N Stanley Lincoln, superintendent of Biggs Memorial Hospital, Ithaca, as president of the New York State Association of Superintendents and Managers of Tuberculosis Sanatoria.

Speakers -Dr Jean A. Curran, president of the Long Island College of Medicine, at a meeting of the Brooklyn Rotary Club, on the need for additional health and medical resources for the people of Brooklyn Dr Alan Gregg, director of medical sciences of the Rockefeller Foundation, at the annual luncheon of the National Committee for Mental Hygiene in New York City, urging cooperation of laymen and professional men in a countrywide mental health program Dr George Pack, attending surgeon, Memorial Hospital for Cancer and Allied Diseases, and clinical professor of surgery, New York Medical College, a lecture on "The Definition of Inoperability of Cancer" at the

annual meeting of the Southern Medical Association in Baltimore, Maryland, on November 25, and two lectures on "Diagnosis and Treatment of Pigmented Nevi and Melanomas" and "Manage-ment of Malignant Tumors of the Soft Tissues" at a cancer seminar held under the direction of the Tumor Clinic, Duval County Hospital, Jacksonville, Florida, on November 14 Dr Joseph I Pascal, New York City, who has been invited to read a paper on "A Graphic Study of the Ocular Muscles" at the Congress of the Pan-American Association of Ophthalmology to be held at the Medical School of the University of Havana, January 4 to 11 Dr Edwin Ramsdell, chief of staff of the White Plains Hospital, at a meeting of disaster chairmen of the Westchester County Red Cross Dr Ralph Sheldon, Lyons town and school health officer, on "Great Men of Medicine" at a meeting of the University Extension Circle, in Lyons Dr S Burt Wolbach, director of nutritional research, Children's Hospital, Boston, who gave the fourteenth Walter M Brickner Lecture at the Hospital for Joint Diseases, New York City, on December 16, on "Skeletal Reflections of Vitamin Deficiencies and Excesses"

New Offices —Dr Charles H. Cole, general practice in Cambridge Dr Wade A. Hastings, veteran of four years' service with the US Army Medical Corps in the Pacific theater, general practice in North Bangor Dr Nicholas Linderman, Army veteran, formerly assistant in the department of anatomy at the University of Buffalo, general practice in Byron Dr Allen Walter Henderson, Syracuse, former lieutenant commander in the US Navy, practice of anesthesia in Watertown Dr Edward J Matthews, Army veteran of the European theater where he was stationed with the First Auxiliary Surgical Group, practice of medicine and surgery in Tottenville, Staten Island Dr J William Milhauser, Brooklyn, general practice of medicine, Hicksville Dr Selden T Williams, Jr, general practice in Attica.

COUNTY NEWS

Albany County

At the annual meeting of the Albany County Medical Society on December 10 election of officers for the coming year was held with a slate submitted by the nominating committee. Six new members were also elected, and reports of officers and committees were heard

Personal experiences in his home country, the Netherlands, at the time of the Nazi invasion were described by Dr A. M. Meerloo of New York City in a lecture at the November meeting of the Albany Society for the Advancement of Psychosomatic Medicine. His subject was "General Implications of Fear in War and Peacetime." Dr Robert R. Faust, precident of the Society was chairman of the meeting.

Bronx County

Dr William Dock spoke on "The Background of Arteriosclerosis" at the November meeting of the Bronx County Medical Society held at the Concourse Plaza Hotel. Discussion of his talk was led by Drs. David Greenberg, Blase Pasquarelli, and Max Weiss.

Members of the Bronx County Society are urged to write their opinions of various topics, to aid the Public Relations Commuttee in its investigation of subjects, which include the Veterans Administration, health insurance plan, fees and the cost of living, a national health program, and the future of medicine.

At a meeting of the Bronx Gynecological and obstetrical Society on November 24 a scientific program which included four lectures was presented. Speakers and thour subjects were Dr L. Caruso "Unusual Neoplasm in a Young Child' Dr J Smoley, "Lymphogranuloma Venenum Complicating Pregnancy" Dr M. J Goodfrend, 'Pregnancy Subsequent to Lymphosarcoma and Dr M. Gottlieb "Suprapuble Extraperitoneal Repair of a Vesicocervical Firstula,'

Dr H. Houston Merritt spoke on Recent Advances in the Therapy of Epilepsy at the November meeting of the Bronx Society of Neurol op and Psychiatry held at the Monteflore Hospital auditorium.

Cattaraugus County

Honoring doctors who had practiced fifty years or more members of the Cattaraques County Medical Boclety held a dinner and meeting November 20 at Salamanca. Members of the Woman & Auxiliary members of the group for the dinner with sixty members of the combined organizations present.

Guests of honor were Dr. and Mrs. A. C. Greecheaf Olean, Dr. P. H. Bourne, Salamanca Dr. and Mrs. Thomas Loughlen, Olean, Dr. J. A. Taggert, Salamanca and Dr. A. W. Smallman and daughter Miss Doris Smallman, Ellicotville

Chenango County

Dr Robert F Korns, assistant director of the Division of Communicable Diseases New York State Department of Health spoke on pollomyelitis at the annual meeting of the Chenango County Medical Society held on Docember 9 at Norwich. The instruction was arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York, in cooperation with the State Health Department.

Erie County

The annual meeting of the Eric County Medical Society was held December 18 at the Hotel Statler Buffalo at which new officers were elected

At its meeting on October 28 at the Hotel Statler the Eric County Society had an afternoon and even ng clinical program with speakers and their topics including Dr. Frank II. Lahey, "Present Concepts in the Surgical Treatment of Peptic Ulcer", Dr. Sidney Farber "Treatment of Cancer in Children and Dr. Louis M. Hellman, "Use of Pitultrin in Obstetrics"

Drs. Rocco N De Dominicis and Milton J Schuls Eric County medical examiners, recently completed a week's refresher course at Harvard University's basic seminar in legal medicine.

Herkimer County

Members of the Herkimer County Medical Society have adopted a resolution calling for an increase of fees commensurate with 'a marked increase in the cost of living as well as in the costs incident to the practice of medicine New and old fees are office call, \$3 (previously \$2), house call \$4 (previously \$3) house call received after 9 r m., \$5 (previously \$4)

Jefferson County

'A Review of Recent Studies Regarding Maternal and Infant Mortality' was the topic of the postgraduate instruction presented by Dr Merton C Hatch, associate professor of clinical obstetries Syracuse University College of Medicine, and Dr Tyree C Wyatt, associate professor of clinical pediatries at the same university at a meeting of the Jefferson County Medical Society on December 11 in Watertown

The instruction was arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York

Monroe County

A message to Governor Dewey and State legislators urging appointment of a commission to study the problems of alcoholism was eart by the Monroe County Medical Society at its October meeting in Rochester Annual election of officers was scheduled for the December session.

Dr Ovid Pearson, a member of the County So-

ciety has prepared a report on eye accidents to children up to 18 years of age covering the five-year period from 1941 to 1946 in Monroe County Dr Clarence R Pearson, representing the Monroe County Medical Society, was one of the speakers at the Alcoholism Institute sponsored by the Rochester Committee for Education on Alcoholism on October 19

At the meeting of the Monroe County Mental Hygiene Society on November 5 in Rochester, Dr Howard Hanson, director of the Eastman School of Music, spoke on "The Emotional Aspects of Music"

Nassau County

Demanding immediate and decisive action on the issue, members of the Nassau County Medical Society, at their meeting on October 28, adopted a resolution disapproving the management and operation of the Health Insurance Plan

The resolution, presented after lengthy discussion at the meeting, attended by almost 150 members, requested all members not to participate in the plan and asked all those now participating in it to sever their relationship as quickly as

possible

A series of Tuesday afternoon postgraduate instruction lectures were arranged for the Nassau County Medical Society during December at the

Nassau Hospital, Mineola

The series included November 25—"Gynecology in General Practice," Dr R Gordon Douglas, formerly associate professor of clinical obstetrics and gynecology, Cornell University Medical College, December 2—"Common Parasitic Infections That Are Encountered in General Practice," Dr John Emmett, instructor in preventive medicine and public health, Cornell University Medical College, December 9—"Dietetic Management of Diabetes," Dr George E Anderson, clinical professor of medicine, Long Island College of Medicine, and December 16—"Peripheral Vascular Aspects of Arteriosclerosis and Aging," Dr A. Wilbur Duryee, attending physician and chief of peripheral vascular clinic, New York Post-Graduate Hospital

The instruction was arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York, in cooperation with the State Department of Health

New York County

At the meeting of the New York County Medical Society on October 27 at the New York Academy of Medicine, Dr Harold B Davidson, president of the Society, gave his maugural address. He maintained that the country's need for greater and better medical care should be solved on a local or state level and should not be enlarged to a national scale, and spoke against the Wagner-Murray-Dingell bill, saying that it failed to make provision for the indigent and added a huge tax burden to supply medical care "efficiently given at the present time to people financing their own care"

Onondaga County

Annual election of officers was held at the meeting of the Onondaga County Medical Society on December 2 at the Hotel Syracuse, Syracuse "Recent Advances in Gastrointestinal Surgery" will be the topic of postgraduate instruction to be presented by Dr John H Garlock, clinical professor of surgery at the College of Physicians and Surgeons, Columbia University, at the meeting of the Onondaga County Medical Society on January 6 at the University Club, Syracuse

Orange County

Psychosomatic medicine was discussed by Dr George E Daniels at the meeting of the Orange County Medical Society on October 14 at Goshen.

The Society's cancer committee, headed by Dr H M Gasparian of Cornwall, announced that public cancer education meetings had been arranged and held in almost all Orange County communities during the past six months

Oswego County

Dr David Goldblatt, associate clinical professor of surgery at the New York Post-Graduate Medical School, spoke on "The Treatment of Burns' and Hand Infections" at the meeting of the Oswego County Medical Society on November 18 in Fulton

The postgraduate instruction was arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York for

the County Society

Queens County

Queens County physicians participated in a discussion program on November 3 at the Horace Harding Hospital, Elmhurst, on the subjects of thrombo-embolic disease and carbon tetrachloride poisoning

Participating were Drs James R. Reuling, Bayside, W Howard Barber, Richmond Hill, Arthur A. Fischl, Long Island City, Edward A. Flemming, Forest Hills, Alfred Angrist, Jamaica, and Louis J Taormina, Elmhurst

. . .

"Rocky Mountain Spotted Fever on Long Island" was the subject of a talk by Dr John K Miller, associate director, Division of Laboratories and Research, State Department of Health, at the scientific meeting of the Queens Pediatric Society held December 1 at Forest Hills

Rensselaer County

On December 11, members of the Rensselaer County Medical Society held their annual dinner meeting and industrial health teaching day in Troy, under the auspices of the County Society, the State Society, and the State Department of Health.

Chairman of the afternoon session was Dr William T Shields, Jr, and opening remarks were presented by Dr Clement J Hendron, vice-

president of the County Society

Speakers included Dr Samuel Kahn, compensation medical examiner of the State Workmen's Compensation Board, on "The Relation of Trauma to Disease", Dr Jesse Tolmach, also on the State Board, on "The Evaluation of Disability", and Dr Joseph L Morse, associate in dermatology and syphilology, New York Post-Graduate Medical School, on "Industrial Dermatoses"

At the evening session, Dr Sherman W Mc-Ilmoyl acted as chairman Dr Paul Reznikoff, professor of clinical medicine, Cornell University Medical College, spoke on "Blood Dyscrasia Produced by Industrial Exposures"

[Continued on page 98]

HOSPITAL NEWS

Training Programs to Improve Hospitals Standings

WiTH more facilities for the teaching and training of doctors, hospitals, aided by the community, can onlarge vital medical services and improve the position of New York among major cities as a medical center according to a recent bulletin of the Hospital Council of Greater New

Hospital beds and clinic material, essential to residency training, were shown in an analysis by the Council to be dissipated in too many small hospitals where such training is not possible. The need for expansion of hospital facilities offers an opportunity to the hospitals and the community for coordinated effort to develop those facilities so that dectors in the various specialties may be trained in proportion

to the needs of the people.

The Council's published 'Master Plan for Hospitals and Related Facilities for New York City' provides for facilities which would make possible residency training programs in all three types of proposed general hospitals—community regional, and central. The community hospital smallest of the three types, is not less than 200 beds. The extent of residency training programs in these proposed hospitals would vary according to the number and concentrations of the various types of clinic material in the different specialties, the Bulletin said

In spite of the fact that hospitals in New York outnumber those in any other of the nine major U.S cities studied the Council s analysis showed that New York is below five of the cities, Los Angeles Cleveland Baltimore St. Louis, and Boston in the percentage of registered hospitals with 200 or more beds. In percentage of hospitals with residency training programs in general medicine and general surgery in these nine cities, the only city lower than New York is the city of Detroit

NEWS NOTES

The Jewish Sanitarium and Hospital for Chronic Discusses of Brooklyn is creeting a new building to provide for an additional 350 beds. Caring for 550 patients daily now the hospital expects its new structure to be available for occupancy in about one year Last year 183 923 free hospital days were made available, according to Isaac Albert, presentage. president.

The Veterans Speech Clinic of Polyclinic Hospital, New York City has resumed its activities in treating veterans with disorders of speech, voice, and hearing.

A new hospital building and laboratory has been planned by the Chenango County Medical Society in cooperation with County authorities, according to an announcement by Dr John A. Hollis, Society chairman. Provision is to be made for 40 or 50 beds in the new building, and another hospital to house 30 beds, is to be erected in the southern part of Chenango County

Corning Hospital was visited by more than 200 area residents at the hospital's second annual "Open House in October Members of the board and the hospital staff served as hosts, and tours of inspection, guided by representatives of the various hospital chapters, were conducted throughout the afternoon.

Plans have been completed for a permanent hospital building for Massena, according to a recent announcement, to replace the present temporary hospital Unlike the temporary hospital the new building will contain private rooms as well as wards.

The Hospital, Sidney has been approved by the Associated Hospital Service of New York as a member hospital under the Blue Cross Hospital Care Plan.

In cooperation with the Peckskill Lions' Club the board of directors of Peckskill Hospital has established an eye clinic for residents of the city and its surrounding area. Operating on Saturday morn-ings, the clinic will be stalled by doctors of the hospital, who will be assisted in clerical work by Lions' Club members.

The Medical Group offering comprehensive year-around medical care for wage carner groups, has been opened at the New York University College of Medicine. Organized by the University's faculty the unit is an outgrowth of the University Clinic, which was formed in 1883 It will occupy quarters at the College of Modicine which have been redecorated and equipped at a cost of more than \$150,000

Speakers at the opening ceremonies of the unit were Dr George Bashr president of the New York Academy of Modicine Dr Harold B David-son, president of the New York County Medical Society Dr Marshall S. Brown, Jr., director of the Medical Group and Sir Raphael Cliento director of social activities of the United Nations Secretariat.

According to a survey in the 1947 edition of the American Hospital Directory, published by the American Hospital Association, 16 675,602 patients were admitted to 6,125 hospitals in addition to 88,000 000 visits in 1946 by outpatients to clinics. Hospital plants were valued at \$4,400 000 000 or approximately \$3 100 per bed an increase of \$180 000 000 over hospital valuation in 1945.

A comprehensive study of the type of hospital Lake Placid needs in the future has been made by Dr Bartholomew Ring, chairman of the Lake Placid Hospital Board The minimum estimate of Placid Hospital Board the size of the hospital is fifty beds, but Dr Ring also called for a wing of twenty-five more beds to care for the resort population of Lake Placid. The present hospital, Dr Ring reported, accommodated 450 patients last year but could not receive 250 more applicants who were forced to seek care else-

Five doctors at St John's Hospital, Brooklyn, under the direction of Dr Merrill M Foote, chief of surgery, coordinated the work in their special fields several months ago for the purpose of estab-lishing a tumor clinic Patterned after the clinic at Memorial Hospital, the St John's tumor clinic is held each Wednesday morning

A vital need for public education to make com-munities "hospital conscious" was sounded at a panel discussion of the Northern New York Hospital Council held recently at the Physicians Hospital, Plattsburg The meeting was attended by representatives of Plattsburg, Malone, Saranac Lake, Tupper Lake, Potsdam, Gouverneur, and Massena hospitals.

A seminar on the Progress of Physical Medicine was held in December at Polyclinic Medical School and Hospital, New York City, with Dr Winfred Overholser, superintendent of St Elizabeth's Hospital, Washington, D.C., as guest speaker Dr Richard Kovacs, director of physical medicine at Polyclinic Hospital, presided More than 100 physicians and physical therapists attended the

Plans are underway for the expansion of Oswego Hospital, according to a recent announcement Two new wings are to be added to the present structure, which also is to be modernized and fire-proofed

Plans for reorganizing and expanding Sydenham Hospital in Harlem, New York City, into an institution combining medical practice with a social approach to community health were announced recently by hospital officials Dr Alfred E. Cohn, author of the plan and member of the hospital's board, said that the hospital will undertake a fourfold program "continued basic hospital service, research and teaching, community exploration for social and medical facts affecting health and welfare, and the publication of a quarterly journal to acquaint the nation, in popular language, with the hospital's findings

PERSONALITIES

Appointed.—Dr Madison B Brown, assistant director of Roosevelt Hospital, New York City, as first assistant director of Johns Hopkins Hospital, Baltimore

Dr Marie Cote as an assistant in pediatrics at Luke's Hospital, Newburgh Dr Erwin W Blatter, previously chief quarantine officer for the Hawanan Islands and a veteran of sixteen years with the US Public Health Service, as executive officer of the US Marine Hospital, Clifton, in an interchange transfer with Dr Leo W Tucker Eaton Freeman, Rochester, as intern at St. James Mercy Hospital, Hornell.

Eleven physicians to the medical staff of the United Hospital, Port Chester, Dr Reid Heffner, New Rochelle, as consultant gastroenterologist, Dr Wilfred D Wingebach, New Rochelle, consultant in neurosurgery, Dr Peter Duncan and Dr Estelle Siker, both of Port Chester, as assistant attending pediatricians

To the courtesy staff Dr Frederick Menick, Port Chester, Dr Benjamin Wells Bullen, Jr, and Dr William C Hennigar, both of Greenwich, Connecticut, Dr David Adler, New Rochelle, Dr Arthur E Laidlaw, Larchmont, and Dr Phillip J

O'Reilly, Mamaroneck,

MEDICAL NEWS

[Continued from page 98]

St. Lawrence County

"Review of Recent Studies Regarding Maternal and Infant Mortality" was presented by Drs Merton C Hatch and Tyree C Wyatt, of the Syracuse University College of Medicine, at the meeting of the St. Lawrence County Medical Society on December 11 at Potsdam.

Saratoga County

Members of the Saratoga Springs Medical Society entertained the children of the Hawley Home, Saratoga, at a Hallowe'en party on November 1. when they took their guests to a circus at the Troy Armory

Ulster County

Dr Eldridge H. Campbell, professor of surgery at Albany Medical College, presented postgraduate instruction on "Differential Diagnosis of the Sciatic Syndrome" at a meeting of the Ulster County Medical Society held on December 9 in Kingston.

Wayne County

"The Diagnosis and Treatment of the 'Acute Abdomen'" was the subject of postgraduate in-struction presented by Dr Leon G Berman, assist-ant professor of clinic surgery, Syracuse Univer-sity College of Medicine, at the meeting of the [Continued on page 99]

NECROLOGY

Harrison Capron Allen, M.D., of Endwell, formerly of Endicott, died on Soptember 15 at the ago of seventy-six. He was graduated from New York University College of Mediene in 1897 Dr Allen was a member of the American Medical Association, the Medical Society of the State of New York, and the American Health Association

Henry Helman, M.D., of New York City died on November 17 at the age of eighty two A con-sulting pediatrician at the Mount Sinal Hospital, with which he had been associated for the past fifty eight years, Dr Heiman had practiced in New York City as a specialist in children's diseases for sixty years He was at one time chief of the pediatric departments at the Mount Sinai and Bronx hospitals. He also was a consultant at the Bronx Hospital and the United Israel Zion Hospital in Brooklyn.

He was a former professor of pediatrics at the New York Polyclinic Medical School former vice-president of the American Pediatrics Society, Dr Heiman was a member of the Academy of Medicine, the New York State and County medical societies, and the American Medical Association.

lie was graduated from Columbia University College of Physicians and Surgeons, in 1800 Richard James Keily M.D. of Now York City, died on November 27 He was forty-three years of age He was graduated from the University of Pennsylvania Medical School in 1928 Dr Kelly was amistant attending dermatologist at Roosevelt Hospital and assistant dermatologist at Vanderbilt Clinic. He was a member of the American Academy of Dermatology and Syphilology the Academy of Medicine, the Metropolitan Dermatology Society the American Medical Association, and the New York State and County medical societies

Martin Kutscher, M.D., of New York City, died on October 31 at the age of sixty four Ho was clinical professor of medicine and associate attending physician at New York Polyclinic Medical School and Hospital Dr Kutschor was graduated from Columbia University College of Physicians and Surgeons, in 1905 For many years he was a member of the staffs of Lebanon Hospital City Hospital on Welfare Island, and Polyclinic Hospital cardiologist and endocrinologist, Dr Kutschor was the author of many medical articles. He was a member of the New York County and State medical societies the American Medical Association, the American Heart Association and the Association for the Study of Internal Secretions

Arthur A. Salvin, M.D., of New York City, died on November 19 He was sixty-six years of age Dr Salvin was attending surgeon at Sydenham Hospital with which he had been associated since A graduate of the University of Zurich in 1911, he had served in Russian hospitals before be came to the United States in 1923 He was a Fellow of the American College of Surgeons, and a member of the American Medical Association, the New York State and County medical societies. He was the

author of many medical papers

Leonard Gruner Weber, M.D., died on November 30 at his home in New York City He was sixty nine years of age. Specializing in internal medi cinc. Dr Weber was on the staff of Manhattan Eye and Ear Hospital and formerly was associated with Lenox Hill Hospital. He was a founder and a Fellow of the American College of Physicians, and a member of the New 1 ork State and County medical societies. Dr Weber was graduated from Columbia University, College of Physicians and Surgeons in 1900

MEDICAL NEWS

[Continued from page 93]

Wayne County Medical Society on December 9 in

Lyons,
The program was arranged by the Council Comical Society of the State of New York, in cooperation with the State Department of Health.

Westchester County

A dinner to celebrate the conquicentennial of the A unner to celebrate the sesquicements was held on November 18 at the Waldorf Astoria Hotel, New York City with Dr William G Childress, White Plains, president of the County Society, acting as chairman. chairman.

Dr Morns Fishbein, editor of the Journal of the American Medical Association, and Dr Louis H Bauer president of the Medical Society of the State of New York, gave the principal addresses

A brief resume of the history of the Westchester County Society since its founding 150 years ago in May 1797 was given by the historian, Dr Laur ance D Redway Ossining, who recently completed a history of the Society in a momorial volume

Dr David Fertig, Hartsdale, and Dr Henry E. McGarvey Bronxville, were cochairmen of the committee on arrangements, assisted by Dr Childress, Dr George C Adle, New Rochelle, Dr Waring Willis, Bronxville, and Dr Isadore Zadek, Mount Vernon.

WOMAN'S AUXILIARY

TO THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

National Conference Held in Chicago

THE Fourth Annual Conference of State Presidents, Presidents-Elect, and National Chairmen of Standing Committees of the Woman's Auxiliary of the American Medical Association was held in Chicago at the La Salle Hotel on November 6 and 7

Mrs Harry F Pohlmann, New York State Auxil-

nary president, was elected recording secretary of the meeting Preceding the conference, Mrs Eustace A Allen, national Auxiliary president, and Mrs Luther H Kice, national president-elect, discussed "Medicine Serves America" on a quarter-hour radio program over NBC in Chicago Transcriptions were made of the broadcast

County News

Broome County The first Health Fair of Broome County, held at the George F Johnson Pavilion, Johnson City, on October 22 and 23, and sponsored by the Broome County Tuberculosis and Public Health Association in cooperation with fifteen other health agencies, was reported to be a great success Fifty-five Broome County Auxiliary members were hostesses at the fair, with Mrs Windsor R Smith, Auxiliary president, as chairman, and Mrs M M Monserrate, Sixth District councilor, as co-chair-

Dr Herman E Hilleboe, New York State Commissioner of Welfare, opened the fair with a challenge to every man, woman, and child in the county to maintain the efficiency of Americans through the prevention of disease Dr E R Coffey, re-gional director of the United States Health Service, was guest speaker, his topic being "Be Your Own

Health Officer "

About 5,000 persons, including 800 school children, visited the fair Broome County's health officials hope to make this event an annual one, and Mrs Smith hopes that other county auxiliaries will instigate health fairs in their counties

Cattaraugus County Doctors who have served the medical profession in Cattaraugus County for forty years were honored by the County Medical Society and its Auxiliary at a dinner at the Dudley Hotel, Salamanca, on November 20 Those honored were Drs A W Smallman, Ellicottville, C A Greenlea and T B Laughlin, Olean, and P H Bourne and James A Taggert, Salamanca John R Armstrong, Ph D, was speaker at the dinner meeting Following the dinner, the Society and the Auxiliary held separate business meetings

The Cattaraugus County Auchary's new project instituted by its president, Mrs. Maurice G. Sheldon, of Olean, is "Rheumatic Fever and Heart Disease," upon which the Auxiliary will work with the County PTA's A film and recording, "Jimmie Beats Rheumatic Fever," has been obtained from the Health Department, and at each showing a doctor from the community will give a brief talk and answer the audience's questions

Brie County The Woman's Auxiliary to the Eric County Medical Society held a round table luncheon and business meeting on November 25 at the Hotel Statler in Buffalo Speakers of the day nere Harold P Jarvis, executive officer of the County Medical Society, and Joseph J Guariglia, secretary-attorney to the Society's Workman's Compensation Committee, whose joint subject was "Medical Legislation" Mrs Arthur L Bennett, president, presided

Richmond County Voluntary services for convalescent children at Sea View Hospital were planned at the November meeting of the Woman's Auxiliary of the Richmond County Medical Society, held in the Villa at St. Vincent's Hospital, Staten Twelve members volunteered to work with a group of 35 children, ranging in age from three to seven years

Speaker at the meeting was Thomas E Walsh, field representative of the Public Relations Bureau of the New York State Medical Society, who discussed the importance of the Auxiliary's purpose, medical care plans, legislation regarding health, and public relations. He was introduced by Mrs Michael R. Mazzei, chairman of the Auxiliary's public relations committee

Mrs Douglas C Neblett reported that the Staten Island Tuberculosis and Health Committee had expressed appreciation for the voluntary work done by Auxiliary members with the mobile x-ray unit

Mrs Charles L Reigi was in charge of the tea that followed the meeting Assisting her were Mrs John J Goller, Mrs Joseph P Takach, Mrs Henry Briggin, Mrs Donato V Catalano, Mrs Joseph V D'Agostino, and Mrs Lewis D Foote Presiding was Mrs Joseph F Worthen, president

BOOKS

RECEIVED

Endocrinology of Neoplastic Diseases. A Symposium by Eighteen Authors. Edited by Gray II Twombly, M.D. and George T. Pack, M.D. Oc-tavo of 392 pages, illustrated New York, Oxford University Press 1947 Cloth, \$11

Diseases of Children. Edited by Donald Pater son, M.D., and Alan Monerieff, M.D. Fourth edition. (First edition edited by Sir A. E. Carrod D.M., Frederick E. Batten M.D. and Hugh Thursfield, D.M.) Volume I, with contributions by twenty nine contributors. Octavo of 771 pages twenty nine contributors. Octavo of 771 pages illustrated. Baltimore, Williams & Wilkins Co 1947 Cloth \$9 00

The Medical Clinics of North America. Clinic Number July 1947 Octavo Philadelphia, W B Saunders Co, 1947 Published Bi-Monthly (six numbers a year) Cloth, \$16 net, Paper \$12

Osteotomy of the Long Bones By Henry Milch, LD Octavo of 294 pages illustrated Spring field, Ill. Charles C Thomas 1947 Cloth 48 75

Concise Anatomy By Lindon F Edwards, Ph D Quarto of 548 pages, illustrated Blakiston Co., 1917 Cloth \$5 50 Philadelphia,

Office Radocrinology By Robert B Greenblatt, M.D. Third edition. Octavo of 303 pages illus-trated, Springfield, Ill., Charles C Thomas 1947 Cloth, \$1 75

Pharmakologie. Als Theoretische Grundlage Einer Rationellen Pharmakotherapie. By Knud O Möller Translated and edited from the third Danish edition by Dr O Walker, Basel Octavo of 744 pages, Illustrated Basel, Switzerland, Benno Schwabe & Co (New York, Grune & Stratton) 1947 Cloth, \$48 Sw Fr

Rhinoplasty and Restoration of Facial Contour With Special Reference to Trauma. By Jacques W Malinizc, M D Octavo of 327 pages illustrated. Philadelphia F A. Davis Co. 1947 Cloth, \$7.50

Diseases of the Galibladder and Allied Structures. Diagnosis and Treatment. By Moses Behrend, M.D. Octavo of 200 pages illustrated Philadelphia F A. Davis Co. 1947. Cloth, \$7.00

Diseases of the Chest. Diagnosis and Treatment. By Archibald Reynolds Judd, M.D. Octavo of 608
pages, illustrated. Philadelphia, F. A. Davis Co
1947 Cloth 89 00

Diseases Transmitted from Animals to Man. By Thomas G Hull Ph.D Third edition. Octavo of 571 pages illustrated. Springfield III Charles O Thomas 1947 Cloth \$10 50

Practical Emulsions. By H Bennett Second edition. Including a Symposium on Emulsifying Agents and Emulsions in Industry Octavo of 508 pages. Brooklyn, Chemical Publishing Co 1947 Cloth, \$8.50

A Manual of Fractures and Dislocations Barbara Bartlett Stimson, M.D Second edition.
Duodecimo of 223 pages illustrated Philadelphia,
Lea & Febiger 1947 Flexible cloth, \$3 25

Developmental Diagnosis. Normal and Abnormal Child Development. Clinical Methods and Ped istric Applications. By Arnold Gesell M D, and Catherine S Amatruda, M.D Second edition. Octavo of 496 pages, illustrated, Philadelphia, Blakiston Co, 1947 Cloth \$7.50

A Hand Book of Ocular Therapeutics By San ford R. Gifford M.D. Rovised by Derrick Vall M.D. Fourth edition. Octavo of 386 pages illustrated Philadelphia, Lea & Febiger, 1947 Cloth \$5 00

Introduction to Medical Psychology By L. Erwin Wexberg, M.D. Duodecimo of 171 pages New York Grune & Stratton, 1947 Cloth, \$3 50

The Rotunda Hospital, 1745-1945 By O Donel T D Browne M B (Ireland) Octavo of 296 pages illustrated. Baltimore Williams & Wilkins Co 1947 Cloth \$11

Symptoms and Signs in Clinical Medicine. Introduction to Medical Diagnosis. By E. Noble Chamberlain, M.D. Fourth edition. Octavo of 463 pages illustrated. Baltimore Williams & Wilkins Co 1947 Cloth \$8.00

Massage and Remedial Exercises. In Medical and Surgical Conditions. By Noel M Tidy Seventh edition. Octavo of 480 pages, illustrated. Balti more Williams & Wilkins Co 1947 Cloth, \$6 00

Internal Medicine in General Practice Robert Pratt McCombs, M D Second edition. Octavo of 741 pages, illustrated Philadelphia, W B Saunders Co 1947 Cloth, \$8.00

The American Illustrated Medical Dictionary Complete Dictionary of the Terms Used in Medicine, Surgery Dentistry, Pharmacy, Chemistry Nursing, Surgery Dentistry, Pharmacy, Chemistry Nursing, Veterinary Science Biology, Medical Biography etc., with the Pronunciation, Derivation, and Defini By Lt. Col. W A. Newman Dorland, M R.C.
With the collaboration of E. C. L. Miller tion. (UBA) With the collaboration of E. O. L. M.D. M.D. Twonty first edition. Octavo of 1 660 pages illustrated. Philadelphia W B Saunders Co. 1947 Flexible Cloth \$8.00 with Thumb Index, \$8.50

Office Treatment of the Eye. By Clias Selinger M D Octavo of 542 pages illustrated Chicago, Year Book Publishers 1947 Cloth, \$7.75

Communal Sick-Care in the German Ghetto. By Jacob R. Marcus Ph.D Octavo of 335 pages Cincinnati, Hebrew Union College Press 1947 Cloth \$4 00

Overcoming Stammering. By Charles Pellman. Octavo of 160 pages. New York, Beechhurst Press 1947 Cloth, \$3.00

Insides Out. Being the Saga of a Drama Critic Who Attended His Own Opening By John Mason Brown Large duodecimo of 202 pages, illustrated New York, Whittlesey House, 1942 Cloth, \$200

New and Nonofficial Remedies, 1947 Containing Descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of The American Medical Association on January 1, 1947 Issued under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association Duodecimo of 749 pages, illustrated Philadelphia, J B Lippincott Co, 1947

Advances in Internal Medicine Volume II Edited by William Dock, M.D., and I. Snapper, M.D. Octavo of 642 pages, illustrated New York, Interscience Publishers, 1947 Cloth, \$9.50

Hospital Care in the United States A Study of the Function of the General Hospital, Its Role in the Care of All Types of Illness, and the Conduct of Activities Related to Patient Service, with Recommendations for Its Extension and Integration for More Adequate Care of the American Public By the Commission on Hospital Care Octavo of 631 pages, illustrated New York, Commonwealth Fund, 1947 Cloth, \$450

Psychiatry for Everyman. By J A C Brown, M B Duodecimo of 247 pages New York, Philosophical Library, 1947. Cloth, \$3 00

The Metropolitan Life A Study in Business Growth By Marquis James Octavo of 480 pages illustrated New York, Viking Press, 1947 Cloth, \$5 00

Essentials of Pharmacology By Frances K. Oldham, Ph D, F E Kelsey, Ph D, and E M K Geiling, Ph D Duodecimo of 440 pages, illustrated Philadelphia, J B Lippincott Co, 1947 Cloth, \$500

Handbook of Psychiatry By Winfred Overholser, M D, and Winifred V Richmond, Ph.D Octavo of 252 pages Philadelphia, J B Lippincott Co, 1947 Cloth, \$4 00

Rypins' Medical Licensure Examinations Topical Summaries, Questions, and Answers Containing for the First Time a Chapter on Psychiatry, Also Numerous Text Changes Throughout Incorporating Current Advances. Edited by Walter L. Bierring, M.D. Sixth edition. With the collaboration of a review panel Octavo of 690 pages Philadelphia, J. B. Lippincott Co., 1947 Cloth, \$600

Calcific Disease of the Aortic Valve By Howard T Karsner, MD, and Simon Koletsky, MD Octavo of 111 pages, illustrated Philadelphia, JB Lippincott Co, 1947 Cloth, \$500

Trichomonas Vaginalis and Trichomoniasis. By Ray E Trussell, M D Octavo of 277 pages, illustrated Springfield, Ill, Charles C Thomas, 1947 Cloth, \$6 00

The Medical Clinics of North America Boston Number September, 1947 Octavo Philadelphia, W B Saunders Co, 1947 Published Bi-monthly (six numbers a year) Cloth, \$16 net, Paper, \$12 net

On Hospitals By S S Goldwater, M D Octavo of 395 pages, illustrated New York, MacMillan Co, 1947 Cloth, \$9 00

Fatigue and Impairment in Man By S Howard Bartley, Ph D, and Eloise Chute, M A Octavo of 429 pages, illustrated New York, McGraw-Hill Book Co, 1947 Cloth, \$5 50 Morphologic Hematology Special Issue No 1 of Blood, the Journal of Hematology Editorial Board, William Damashek, M D, Editor-in-Chief Large Octavo of 200 pages, illustrated New York, Grune & Stratton, 1947 Cloth, \$4 75

Public Health Law By James A Tobey, Dr PH Third edition Octavo of 419 pages New York, Commonwealth Fund, 1947 Cloth, \$4 50

Kompendium der Parasitischen Wirmer im Menschen. By Dr Hans A Kreis Octavo of 136 pages, illustrated Basel, Switzerland, Benno Schwabe & Co, 1947 Cloth, 10 fr

An Introduction to Biochemistry By William Robert Fearon, MB Third edition. Octavo of 569 pages, illustrated New York, Grune & Stratton, 1947 Cloth, \$600

Manual of Physical Diagnosis with Special Consideration of the Heart and Lungs By Ellis B Freilich, MD, and George C Coe, MD Revised in collaboration with Joseph K. Freilich, MD Third edition. Large duodecimo of 351 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth, \$500

Calcium and Phosphorus in Foods and Nutrition. By Henry C Sherman Octavo of 176 pages, illustrated New York, Columbia University Press, 1947 Cloth, \$2 75

Headache By Louis G Moench, M D Large duodecimo of 207 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth, \$3 50

Hodgkin's Disease and Allied Disorders By Henry Jackson, Jr , M D , and Frederic Parker, Jr , M D Quarto of 177 pages, illustrated New York, Oxford University Press, 1947 Cloth, \$6 50

Endogeneous Endocrinotherapy Including the Causal Cure of Cancer Compendium By Dr Jules Samuels Octavo of 539 pages, illustrated Amsterdam, Netherlands, Holdert & Co, 1947

Stereoscopic Atlas of Neuroanatomy By H S Rubinstein, M D, and C L Davis, M D Quarto 43 plates, and descriptive pamphlet of 19 pages Illustrated New York, Grune & Stratton, 1947 \$10 set

Beiträge zur Kenntnis der Blutgerinnung By Prof W K Rieben Octavo of 96 pages, illustrated Basel, Switzerland, Benno Schwabe & Co (New York, Grune & Stratton), 1947 Paper, 9 Sw fr

Applied Physiology By Samson Wright, M D Eighth edition Octavo of 944 pages, illustrated New York, Oxford University Press, 1945 Cloth, \$9 00

The Practical Nurse By Dorothy Deming, R N Octavo of 370 pages New York, Commonwealth Fund, 1947 Cloth, \$3 00

Communicable Diseases By Franklin H Top, M D, and collaborators Second edition Octavo of 992 pages, illustrated St Louis, C V Mosby Co, 1947 Cloth, \$8 50

Diagnostic Bacteriology A Textbook for the Isolation and Identification of Pathogenic Bacteria for Medical Bacteriology Laboratories By Isabelle Gilbert Schaub, AB, and M Kathleen Foley, AB Third edition Octavo of 532 pages St Louis, CV Mosby Co, 1947 Cloth, \$450

Synopsis of Obstetrics. By Jennings C Litzenberg, M.D Third edition Duodecimo of 416 pages, illustrated St Louis, C V Mosby Co, 1947 Cloth, \$5 50

REVIEWED

The 1946 Year Book of General Medicine Edited by George G Dick, M D, J Burns Amberson, M. D, George R. Minot, M D et al Duodeelmo of 772 pages illustrated. Chicago Year Book Publishers 1946 Cloth, \$3.75

As always the 1 car Book of Medicine contains ex tremely interesting and frequently useful information. As usual it is difficult to pick out the most striking reviews Those on kidney diseases and cardiology are especially good. This volume in cludes a well-deserved tribute to the late Sir Thomas Lewis. This volume, as those of other years should be on every medical man's shelf.

ANDREW BABEY

X-Ray Diffraction Studies in Biology and Medicina. By Mona Spiegel-Adolf, M.D. and George C Henny M.D. Octavo of 215 pages, illustrated New York, Grune & Stratton, 1947 Cloth \$5.50

The atom has become more than just a byword of our postwar existence It not only enters into the science of physics and chemistry but into our body politics and now actually into the province of biology and medicine.

As long ago as 1912, crystals were shown to constitute a three-dimensional diffraction pattern to the x-ray beam. More recently by these diffraction studies it has been shown that silk fiber, living nerve, and muscle are also composed of a regular pattern arrangement of their atoms and molecules In fact, an amorphous structural setup among molecules is a rare occurrence in nature

The theory of x ray diffraction is clearly presented with but few mathematic formulas to confuse the untrained reader The apparatus used by the authors is described adequately and is well illustrated. The book serves as an excellent introduction to the study of the exact interarrangement of the molecular and atomic particles in matter
WILLIAM E HOWES

Psychiatric Interviews with Children. Edited by Helen Leland Witmer Quarto of 443 pages New York, Commonwealth Fund, 1946 Cloth, \$4.50

This Commonwealth Fund publication is a re-cording of the psychiatric management of 10 children in various child guidance clinics. Each coding of the psychiatric management of a children in various child guidance clinics. Each contributor has attempted to show how a satisfac-tory colution was reached through the use of par-ticular technics, and the reasons therefor. This book will be of particular interest to students of Daybothesan in abilities and to practitionars of psychotherapy in children and to practitioners of child psychiatry STANLEY S LAND

Handbook of Physiology & Biochemistry milly "Kirk's" and later "Halliburton"s." By R. J. 8 McDowall, M.D. Thirty ninth edition. Large duodecimo of 808 pages illustrated Phila-delphia, Blakiston Company 1946 Cloth, 87 00

This book on the physiclogy and chemistry of the human book on the physiciogy and unchanged the human body has been brought up to date by revision of the previous edition. New additions have been made to the chapters deeling with metabolism osmotic activity the effects of high altitude rickets and myxedema. The interglandular relationships tionships especially the pituitary and adrenals are vividly presented. The structure and function of the cerebrospinal system, including cerebellar localisation, are well described The text is profusely illustrated and well printed

EDWARD II NIDISH

Allergy in Theory and Practice By Robert A Cooke, M D In association with Horses S Bald win, M D Robert Chobot M D R. Clark Grove M D et al Octavo of 572 pages, illustrated Philadelphia W B Saunders Company 1947 W B Saunders Company 1947 Cloth, \$8 00

This volume is the ultimate outcome of several programs of postgraduate instruction in allergy directed by the author Thirteen of the thirty three chapters were written by Dr Cooke The book will prove to be interesting reading and also provide valuable important and appelalist in allergy
MAX HARTEN provide valuable information to the student, general

Synopsis of Operative Surgery By H. E. Mobley, M.D. Second edition Duodecimo of 416 pages illustrated. St. Louis C V Mosby Company 1947 Cloth, \$6 00

This second edition is notable for its comprehen sive presentation of the many types of operation that the general surgeon is called upon to perform The technic of the standard operations is adequately albeit concisely described and clarified by abundant illustrations many of which are in colors The book is very readable and contains a wealth of practical information in clear and condensed form. It should prove helpful both to the prospective young resident and the older practicing surgeon

Автиив Состаси

Experiences with Folic Acid. By Tom D Spies M.D Octavo of 110 pages illustrated. Chicago Year Book Publishers 1947 Cloth \$3.75

This book is an extremely enthusiastic review of the role of folic said in macrocytic anomia. Whether this enthusiasm will continue and whether it is warranted will be shown by further clinical experi ence. The use of folic acid for producing blood regeneration in persons with Addisonian pernicious anemia, nutritional macrocytic anemia, and its use in macrocytic anemia of sprue pregnancy and pellagra is described.

As a book full of enthusiasm combined with a pleasant presentation of knowledge it is recommended reading for the clinician.

HENRY M FEINBLATT

Practical Physiological Chemistry By Philip B Hawk, Ph.D Bernard L. Oser, Ph.D and William H. Summerson, Ph.D. Twelfth edition. Octave of 1.823 pages, illustrated. Philadelphia, Blakiston Company 1047 \$10

Hawk s book in all its forty years of authoritative existence, never before has had a decade elapse be-tween editions. New and transitional blochemical alterations of this active period have necessitated an over-all revision with extensive additions totaling to a new volume 30 per cent larger than the previous edition. Obsolete methods have been deleted and new procedures admitted, particularly for blood and urine analysis. Integration of the older and recent phases has been admirably accomplished The book is up to date, wonderfully edited, printed on excellent paper, and is attractively bound. Its distinguished history of usefulness as text and reference work is enhanced by the present edition

IRVING M DERBY

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1946 135 pages Chicago, American Medical Association, 1947 Cloth, \$1 00

This volume was formerly of most interest to those who wished to know why the Council on Pharmacy and Chemistry had not accepted certain of the preparations it had considered. The reports were mainly those of rejection, though, through the years, the educational nature of the Council's work was attested by status reports on drugs, or therapeutic procedures, or preliminary reports on agents showing promise of usefulness but not yet ready for adoption by the general and medical profession In adoption by the general and medical profession recent years, the tendency has been toward a preponderance of the educational type of report the present volume, both the condemnatory and the educational phases of the Council's work are represented

There are three reports of vigorous condemnafirst, the report on cabasil, a curiously unscientific mixture whose exploitation for use in a multitude of diseases is aptly summarized by the subtitle of the report, "Quackery Unlimited", second, the report on the pseudoscientific Ethylene Disulphonate (Allergosil brand), a preparation of highly uncertain nature exploited by physicians for use in allergic conditions, third, Formula A-N-1, a joint report of the Council on Pharmacy and Chemistry and the Council on Industrial Health, concerning an expensive but poor substitute for aspirin and citrate of magnesia, cleverly promoted to industrial concerns for use in reducing absenteeism due to colds

Among the status reports, the excellent article of Dr Samuel M Feinberg, "Histamine and Antihistaminic Agents," is probably most worthy of Since its appearance, the Council has accepted for inclusion in New and Nonofficial Remedies, the two new agents of this class evaluated in the article, Diphenhydramine Hydrochloride, and Tripelennamine Hydrochloride (Benadryl Hydrochloride and Pyribenzamine Hydrochloride, respectively)

Pharmaceutic and scientific investigators, alike, will be interested in the informative report on the Council's new Therapeutic Trials Committee special interest to manufacturers is a statement on the revised rules of the Council, though this exposition of the trends of Council policy is of concern to all who are interested in progressive rational

therapeutics

Attention is called to the several reports on the adoption of generic designations for drugs proposed or marketed under protected names Not all such actions of the Council have been the subject of separate published reports, the recognized terms have appeared in the published descriptions of the drugs when accepted, and will be inserted in another Council publication, New and Nonofficial Reme-dies, as adoption of such designations for already accepted protected names proceeds

New and Nonofficial Remedies, 1947, Containing Descriptions of the Articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1947 749 pages Philadelphia, J B Lippincott Company, 1947 Cloth, \$3 00

Although the latest edition of New and Nonofficial Remedies has some 11 pages fewer than the 1946 book, its increase in size, due to the heavier paper used, and its change of color—dark green to bright red—combine to make a striking contrast with The book is now pubthe earlier annual volumes lished by J B Lippincott Company, though it is still issued under the direction and supervision of the Council on Pharmacy and Chemistry innovation is the relegation of the statements of tests and standards to the back of the book, which makes the text more convenient and usable for the physician, for whom it is primarily intended understood that supplements to the annual volumes no longer will be issued The physician who is interested in current acceptances can keep track of these as the descriptions are published in the Journal of the A M A, or may inquire about them by addressing the Council's office at A M A headquar-Several medical and pharmaceutic journals now carry lists of currently accepted products

There appears to be no very extensive revision in the various general articles or chapter-head discussions, although several new monographs have made their appearance and others have been revised to reflect current medical opinion. One notes the appearance of a new chapter, "Unclassified Therapeutic Agents," which includes the mono-graphs on Gold Compounds and Iodine Compounds for systemic use This is in line with the policy adopted some years ago of classifying accepted preparations according to pharmacologic action and

therapeutic use

Attention is called to the amplification and indexing of the section devoted to the statement of the Council's rules This should be of great assistance to manufacturers in the presentation of products for Council consideration and is no doubt inspired by the recent marked increase in the number of pharma-

ceutic concerns asking Council recognition The descriptions of some thirteen new preparations appear in this volume. This excludes, of course, brands or dosages of already accepted Among those preparations noteworthy of mention are the pertussis vaccines and vaccines representing combinations of pertussis with diphtheria and tetanus organisms, the new histamine-antagonizing agent, Benadryl Hydrochloride Elixir (Diphenhydramine Hydrochloride Elixir), Furacin (Nitrofurazone) a new topical anti-infective agent, Streptomycin, Heparin Sodium, Parenamine, a new casem hydrolyzate, Thiouracil, an antithyroid agent, Naphuride Sodium (Suramin Sodium) a new trypanocide, and tuamine (Racemic 2-aminoheptane), a new vasocontrictor One notes the increasing appearance of generic designations in conformance with the revised Council's rules on acceptance of agents bearing protected or trade-marked names

New and Nonofficial Remedies remains a most valuable and authoritative compendium of modern rational therapeutics With successive editions, it becomes more useful and accessible to the physician and to all those interested in the use, preparation, or

manufacture of drugs

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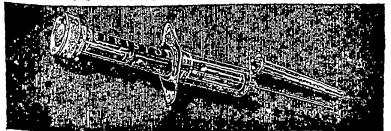
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THE UNIVERSITY OF THE STATE OF NEW YORK THE STATE EDUCATION DEPARTMENT BOARD OF MEDICAL EXAMINERS

Dr W P Anderton, Secretary Medical Society of the State of New York 292 Madison Avenue New York 17, N Y

Dear Dr Anderton

This is to notify you that the Board of Regents at a meeting held September 19, 1947,

VOTED, That the determination of the Medical Committee on Grievances in the matter of the application for the revocation of the medical license heretofore granted to Domenico Paccione, New York City, be accepted and sustained, that, in compliance with the recommendation of said committee, said Domenico Paccione be censured and reprimanded, that said Domenico Paccione be ordered to appear for such censure and reprimand before the Board of Regents at a time and place to be determined by the Commissioner of Education, notice of which shall be given to said Domenico Paccione by said Commissioner, and that the Commissioner of Education be empowered and directed to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote

Dr Paccione is registered for the year 1947-1948 from 100 West 42nd Street, New York City The above order was served on Dr Paccione on September 30, 1947

(Signed)
JACOB L LOCHNER, JR., M D, Secretary
N Y State Board of Medical Examiners

Dear Dr Anderton

This is to notify you that the Board of Regents at a meeting held September 19, 1947,

VOTED, That the determination of the Medical Committee on Gnevances in the matter of the application for the revocation of the medical license heretofore granted to Abraham S Kagan, New York City, be accepted and sustained, that, in compliance with the recommendation of said committee, said Abraham S Kagan be censured and reprimanded, that said Abraham S Kagan be ordered to appear for such censure and reprimande to be determined by the Commissioner of Education, notice of which shall be given to said Abraham S Kagan by said Commissioner, and that the Commissioner of Education be empowered and directed to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote

Dr Kagan is registered for the year 1947–1948 from 127 West 58th Street, New York City The order of the Commissioner was served on Dr Kagan on October 1, 1947

(Signed)
JACOB L LOCHNER, JR., M D, Secretary
N Y State Board of Medical Examiners
October 24, 1947

To the County Clerks of New York State Gentlemen

This is to notify you that the Board of Regents at a meeting held July 31, 1947,

Voted, That the determination of the Medical Committee on Grievances in the matter of the application for the revocation of the medical license heretofore granted to William P E Berwald, Syracuse, be accepted and sustained, that, in compliance with the recommendation of said committee, medical license No 30878, issued under date of June 27, 1935, to said William P E Berwald, permitting him to practice medicine in the State of New York, and his registration or registrations as a physician, wherever they appear, be suspended for a period of one year from the date of service of the order effecting such suspension, and that the Commissioner of Education be empowered and directed to execute, for and on behalf of the Board of Regents, all orders necessary to accept the determination of said Committee on Grievances and to carry out the terms of this vote

Dr Berwald was registered for 1947–1948 from Suite 1804, State Tower Building, Syracuse, New York. The order of the Commissioner of Education was served on Dr Berwald on August 22, 1947

(Signed)

JACOB L LOCHNER, JR., M D , Secretary

N Y State Board of Medical Examiners
October 29, 1947

To the County Clerks of New York State Gentlemen

This is to notify you that the Board of Regents at a meeting held September 19, 1947,

Voted, That, pursuant to the provisions of subdivision 1 of section 6514 (formerly section 1264) of the Education Law, medical license No 20223, issued under date of January 28, 1926, to Herman L Kasha, New York, permitting him to practice medicine in the State of New York, be revoked, annulled and canceled, and that his registration or registrations as a physician, wherever they may appear, be ordered annulled and canceled of record, and that the Commissioner of Education be empowered and directed to execute for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote

Dr Kasha was registered for the year 1947-1948 from 7 West 75th Street, New York City The order of revocation was served on Dr Kasha on September 30, 1947

JACOB L LOCHNER, JR., M D, Secretary
N Y State Board of Medical Examiners
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The New York State Journal of Medicine asks its contributors to follow the suggestions listed below in the preparation of their articles. In this way they will greatly facilitate the expeditious publication of the Journal. These suggestions have been devised in order to save correspondence, avoid return of papers for changes, minimize the work of preparation for the printer, and save the high costs of corrections made on galley proof

Size of Articles —It is earnestly desired that scientific articles shall not exceed 6 JOURNAL pages at the outside Longer articles tend to lower reader interest. An average of five or six seems to be the most desirable from this point of view Calculation can readily be made by multiplying the number of double-spaced typewritten manuscript pages by the fraction two-fifths, e.g., twelve manuscript pages will make five JOURNAL pages

Manuscripts —Papers must be typewritten on one side only of white sheets consecutively numbered, and be double spaced with one-inch margins. They should be prepared with great care so as to be typographically correct. All headings, titles, subtitles, and subheadings should be typed flush with the left-hand margin. This is imperative for rapid and accurate composition by the printers.

Titles.—The title should be brief and typed in capital letters. The subtitle can be longer and should be typed in caps and lower case letters. Under the title, or subtitle, if there is one, should appear the name of the author and city in which he lives. Directly under his name should be the hospital or institution with which he is affiliated.

Subheadings.—Subheadings should be inserted by the author at appropriate intervals

References—It is the unfaling practice of the New York State Journal of Medicine to use specific "references" rather than "bibliography" There should appear in the text reference numbers, typed above and to the right of the word to which there is a reference. A list, consecutively numbered, of these references should follow at the end of the manuscript (Note that spelling in list is same as in text). The arrangement should be as follows and should include all items.

Books—author's surname followed by initials, title of book, edition, location and name of publisher, year of publication, volume, and page number Thus, Osler, W Modern Medicine, 3rd ed., Philadelphia, Lea & Febiger, 1927, vol. 5, p. 57

b Periodicals—author's surname followed by

initials, name of periodical, volume, page, month (day if necessary), year of publication Thus, Leahy, Leon J New York State J Med 40 347 (March 1) 1940

Note The Journal does not include titles of articles

Case Reports —Instead of abstracts of hospital histories, authors should write these reports in a narrative style with properly completed sentences All unimportant details should be deleted with such general negative statements as fit the case

Tables —While tables are very useful on lantern slides in the reading of papers, they fail of this purpose to a large extent in the printed page. For that reason it is urged that they be reduced as much as possible to descriptive language.

Illustrations —These should be kept to the minimum necessary to make clear the points to be registered by the author. In some instances they are imperative to proper understanding, in others they are merely picturesque. The latter can be excluded to good effect, both as to space and the not

inconsiderable cost

When illustrations are to be used they should accompany manuscripts and each should always be referred to in the text, preferably by number Drawings or graphs should not be larger than 12 × 16 inches, and must be made with jet black India Do not use typewriter for letterink on white paper The smallest lettering on 8 × 10 inch copy should be no less than 1/2 inch high Cross-section paper (white with black lines) may be used, but should not have more than 4 lines per inch finer ruled paper is used, the major division lines should be drawn in with black ink, omitting the finer In the case of finely ruled paper, only blue-lined paper can be accepted Lettering and all markings must be large enough to be readable Mail rolled or flat, never fold after reduction Photographs should be very distinct and show clear black and white contrasts They must be on glossy Avoid round and oval photographs white paper

Whenever possible "crop" photographs, i.e., mark portion that can be excluded when reproduced Crop marks should be on margin of photographs Do not run pencil lines through photographs

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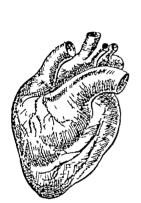
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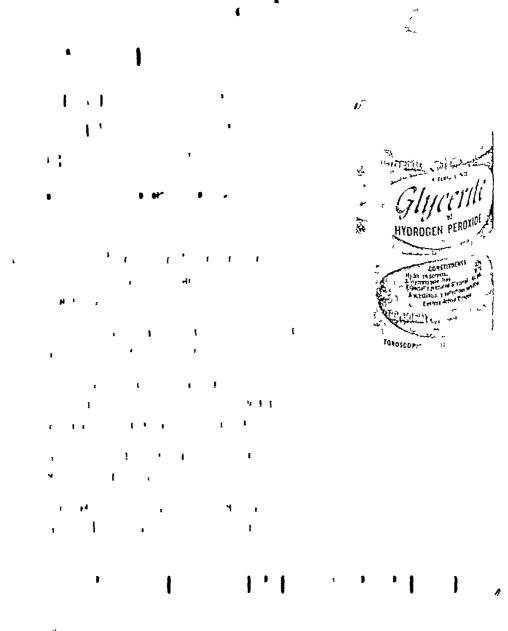
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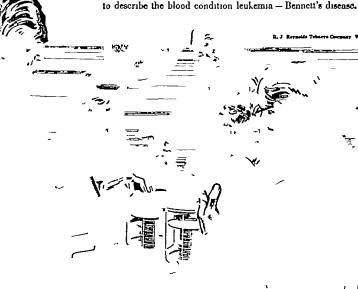


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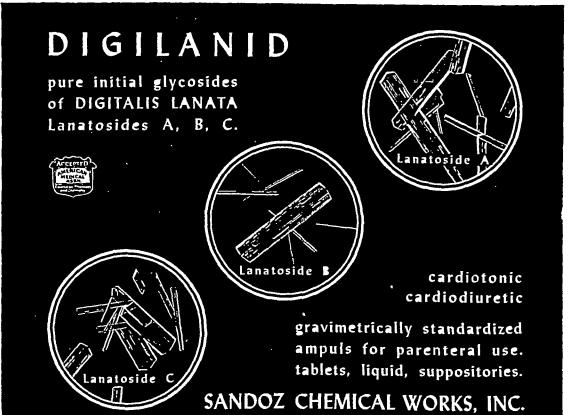


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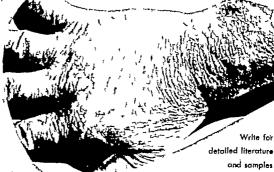


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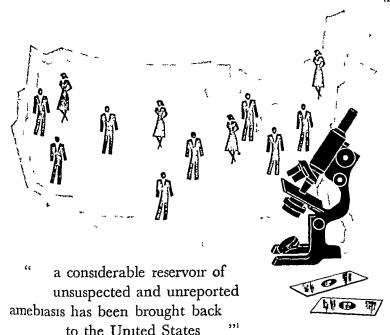
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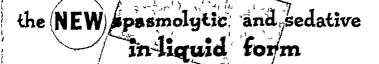
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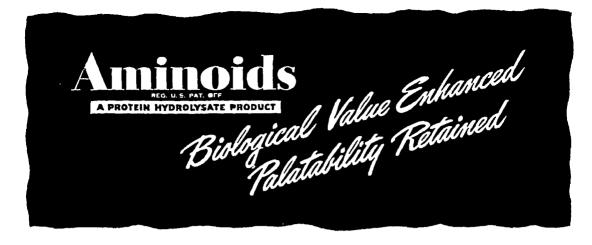
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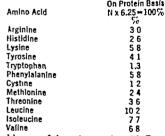
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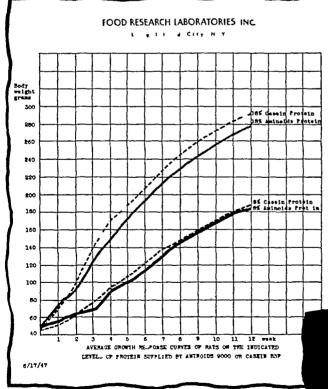


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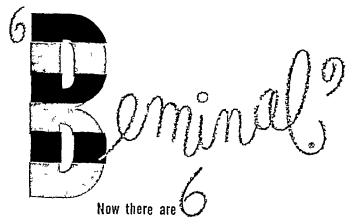
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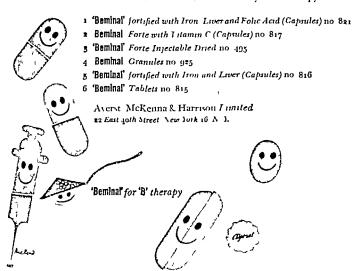


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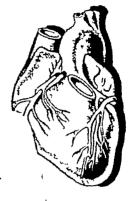
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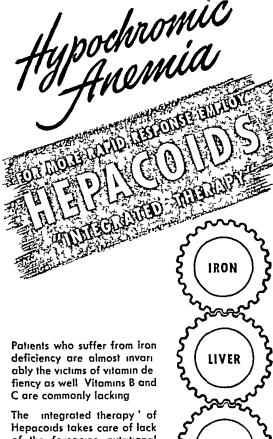
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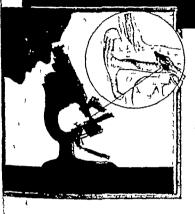
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BIBLIOGRAPHY

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- 2 Thorn, G W and Tyler F H. Med. Clin. North America, Sept. 1947 p 1081
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Editorials

1111* The District Branches

In 1884 then, two State medical organizations existed side by side The Medical Society of the State of New York with its tomponent County Societies,2 and the seceding New York State Medical Association with its five District Branch Associations. The new Association was not official It could and did send representatives to the A.M.A., it did support the national code of cines and carried on an independent existence for many years

in "the last few years of the nineteenth century," says Walsh, "the sentiment began to make itself felt very generally throughout the medical profession of New York State that the maintenance of two State medical organizations was without any proper reason

Many New York City physicians belonged "to both their county medical ociety and their county medical associa-

In 1898, the State Medical Society changed its arrangement of Districts A special committee proposed "as the basis for the adoption of the Judirepresentation cial Districts of the State as given in the Legislative Annual of 1897, in the place of the so-called Senatorial Districts." This change was to be accomplished at the next annual session in 1899

Looking to a reunion of the two medical bodies, a Joint Committee of Conference was appointed by the Association and the Society in 1902 This was continued with different personnel in 1903, five members from each organization composing it. In 1904 arrangements for the consolidation of the two organizations were progressing favorably In 1905, Dr Eliot Harris' of New York reported to the House of Delegates of the AM.A. that before the next annual session, "The medical profession of

Continued from January 1 issue, p. 44.
Shibuts of April 4, 1806 April 3 1807 April 10 1812.

Act of March 22, 1707

I Trans. Med. Soc. State of N Y., 1893, p. 1819 History of the American Medical Association, Fishbein, 1947 p. 238.

the State of New York would have united, and he asked that a committee be appointed to apportion a proper number of delegates to that state"

In 1906, the bylaws of the eight District Branches were adopted (files in the office records of the Med Soc State of New York) in accordance with Chapter VIII, Section 4, of the Bylaws of the Medical Society of the State of New York, adopted in 1904 the reunion of the two groups the Medical Society of the State of New York acquired the District Branches and also retained its County Societies which were from then on grouped into eight divisions following the udicial districts of the State Thus was closed a period of twenty-two years and more of division and dissension in the medical profession of the Empire State

In 1925, at the suggestion of Drs Harry Trick and Eliot Harris, Dr Joseph Lawrence, Executive Officer of the Medical Society of the State of New York, officially assumed the responsibility for the programs and arrangements of the Branches As late as 1927, there existed the Western New York Society of Physicians, the Central, and the Long Island Society of Physicians The functions of these Societies were taken over in that year by the District Branches of the Medical Society of the State of New York by common consent

Between 1930 and 1935 the scientific programs of the county society meetings had a tendency to be predominantly surgical in character. However, when the meetings of the District Branches came under the direction of the Executive Officer this defect of the county society meetings was recognized and the interest of the District Branch meetings was heightened by changing the character of the topics to a more general nature

The original function of the District Branches has largely been lost to view They well served their purpose in the past of forwarding medical education and stimulating interest in meetings because of their large groups. Also the county societies were in many instances token organizations in the early days. Chapter VII, Section 12 of the current Bylaws of the Medical Society of the State of New York (p. 26, 1946)

states "Each President of a District Branch shall visit the County Societies of his district at least once a year and make a careful inquiry of the condition of the profession in each county of his district and shall report thereon to the House of Delegates" The origin of this directive is plain. It served its purpose in the past. How often is it done now?

This brief review of the history of the Branches raises the question of their present usefulness in view of the numerous scientific societies which have been formed in the last fifty years and to which most of the membership belongs in one category or another These numerous scientific societies actually fill the need now for which the District Branches were originally created Only their historical significance remains This is particularly true in the case of those Branches centered around large cities, but is not always the case, be it said, with reference to those Branches which are largely rural in location

A few years ago the officers of the District Branches were polled as to their opinions concerning the advisability of continuing the Branches in view of the relatively poor attendance at the meetings. The officers thought they should be continued. As far as we are aware the membership of each District Branch has never been queried similarly. Might it now be advisable to do so?

Four things might be asked (1) Do you favor continuing the District Branch meetings? (2) Would you advise the continuance of the scientific sessions? (3) If not, would you advise holding the meetings, but purely as a social function for the purpose of serving as a regional conference between the officers of the Society, the officers of the Branches, and the membership of the constituent county societies? (4) Should the regional conferences be devoted to consideration of legislative and economic matters which, latterly, have become of increasing significance to organized medicine?

The Journal invites your opinions on these questions Correspondence addressed to the editors will be placed in the hands of the Secretary of the Medical Society of the State of New York for his information

More Nurses Needed

Our latest information is that about 42,000 more nurses are needed in this country merely to meet the existing shortage. In addition, some 60,000 will be needed to meet mcreasing demands. According to Hygera 1

A survey made by the American Hospital Association indicates that the number of nurses necessary to supply the needs of the hospitals and the people of the United States is 300,000 Over 90,000 nurses are needed for private duty nursing in which one nurse takes care of one patient. At present almost 42,000 nurses are needed to meet the shortage that prevails probably at least 60,000 are needed promptly to meet increasing demands that will come with new hospitals and new services for nurses

Various reasons have been alleged to be responsible for the existing shortage. Before the war nurses worked in many instances a 12-hour day for six days a week. Now throughout much of the United States they work eight hours a day five days a week. This alone would mean almost twice as many nurses to

meet the same needs ...

In 1945, according to the same source, some 16 million patients entered the hospitals, as compared with 10 million in 1940 New hospital construction is under way now, and more is anticipated Hospitalization insurance is spreading rapidly and will probably increase the demand for beds

Under the arcumstances, adequate nursing care becomes more and more a matter of concern, particularly with regard to bedade nursing Whereas this nursing shortage is of vital interest to the medical profession, it should be of even greater concern to the public. In the final analysis, nurses must be recruited from the population in general, the medical profession cannot supply them although it can help instruct them. Why is there not a sufficient meentive for young women to study nursing?

During 1945 a careful survey was made of medical and public opinion regarding the profersion of nursing. The general belief seemed to prevail that the nursing profession is desirable but that it offers too little reward to those who practice it and too high a cost to those who need it. This is like the situation in which

an irresistible force meets an immovable object. How to reconcile the two aspects of this situation is an exceedingly difficult problem

The profession of nursing today includes far more than just taking care of the sick. Nurses have positions involving administrative responsibilities. They are concerned with education. The career of a nurse is considered suitable preparation for specialized training in physical therapy public health, and such fields as psychiatric, orthopedic, surgical, and obstetric nursing. The demand for properly qualified nurses is so great that a girl who completes her education in nursing need never be without work once she has secured a hierase to practice.

It should be conceded that in recent years many more careers in business and industry have become possible for women. Thus the field of competition has been enlarged over the time when nursing and teaching were, generally speaking, about the only careers acceptable.

The minimum educational requirements of most schools of nursing is graduation from high school. Some nursing is graduation from high school. Some nursing schools require one or more years of college work. In general students are admitted only when they have been in the upper third of the class. The preferred age is 20 to 25 years, but 18 years of age is con aidered acceptable in a good many schools. Thirty five is considered the upper limit. Some schools of nursing offer a combination four or five-year program which includes a diploma for nursing and a college degree These schools will admit high school graduates at 17 years of age.

The great number of nurses who get married soon after entering the profession is an indication that this is one profession which is excellent preparation for marriage. The gril who is trained as a nurse has several advantages over girls in other occupations when it comes to contact with the susceptible male...

It would seem that the best approach to the problem of getting more nurses would be an intensive campaign by the nursing profession itself. Unlike the weather, about which very few do anything but talk, something can be done, but it will take hard work first, the nurses themselves will have to "sell" nursing as a career to many more

Dec., 1947

young women and their parents To be convincing, this will mean personal contact, perhaps in the hospital, often in the home, sometimes by personal appearance at school assemblies in cooperation with local school authorities

Nursing associations will have to initiate campaigns of public education, in women's magazines, in the press, at meetings of women's clubs

The national and the several state medical societies can be of great assistance. Dr Edward Bortz, president of the AMA, has already appointed a committee to survey the nursing problem in the United States. The state medical societies through the cooperation of their women's auxiliaries can and assuredly will assist.

Says Hygera further

Much discussion has been going on in medical and nursing circles as to the desirability of educating more practical nurses. The excellent work the nurses' aides did during the war has emphasized this possibility. The criticism is made that professional nurses have raised

their educational standards and are getting far away from bedside nursing In Michigan the State Board of Education in cooperation with medical and nursing organizations has established six practical nurses' training centers to educate such nurses For a number of years Detroit has had a similar project tical nurses are recruited from the senior students in high schools The teachers are registered nurses on high school faculties tical nursing will be a part of the vocational educational system Standards for practical nursing systems will be established leaders who are developing this plan assert that nurses of this type will be able to do from 80 to 90 per cent of the ordinary bedside nursing in hospitals This may be the answer to the major portion of the problem

While more practical nurses are certainly to be desired, the primary objective should be the stimulation of young women by all available means to consider the full training course. In our view this is primarily the obligation of the nursing profession itself with all the assistance organized medicine and its individual physicians can summon

The Voluntary Hospital

We are reprinting herewith, slightly abridged, a statement received from the president of the Board of Trustees of one of the oldest and most respected voluntary hospitals of New York City—It is of the 400–500 bed class and probably typical of the situation elsewhere in the country—Seriously, it makes our blood run cold—Is there one among us who remembers what the term "voluntary" means? "Done, acting, able to act, of one's own free will, not constrained"

In days when people had money to leave they left it first to their children, then to some charity of their own, and often a final sizable amount to a voluntary hospital. The bequest to the hospital was a genuine response to the feeling, more prevalent in those days than the "liberals" of nowadays would have us think, that money carried with it responsibility and that one of the first of those responsibilities was the decent care of the sick poor

Now read

The voluntary hospitals are in a very difficult position, and one which might well cause many of them to close if the conditions do not change

The hospital is efficiently run and has a fine reputation. In spite of its age and reputation it has only approximately \$1,000,000 of endowment and reserve working funds of not more than \$200,000.

In spite of the fact that the fund-raising campaign has resulted in twice as much money being contributed this year, rising costs have used up this money faster than it could be accumulated, with the result that the meager working capital of the hospital is constantly being eaten into

There are only three or four hospitals in the city that will be able to endure such a strain for any length of time, and the demands upon all the hospitals are growing

There are two reasons for this precarious position that we find our voluntary hospitals in now One is the rising costs of food and services For example, the raise in the price of

meat two weeks ago increased the cost of meat for this particular hospital some \$4,000 a month. The increase of a penny in the price of milk increased the cost \$1,200 a month Second, the loss incurred by the care of the sick poor of the city This is of the greatest importance.

The city pays the voluntary hospital \$6 a day for city patients The most efficient hospitals run a cost of between \$11 and \$12 a day for the care of such patients, creating a deficit of \$5 to \$6 per day This strain is too great It cost the hospital used as an example in this article, \$189,000 out of pocket, to care for these city patients in 1946, when the city paid \$4 50 per day The city raised the rate to \$6 in 1947, but in spite of that raise it will cost this particular hospital in the neighborhood of \$150,000 in 1947 to take care of city patients. The city administration is well aware of the difficulties They are finding it in their own hospitals as well as the voluntary hospitals.

The total amount needed to bring the voluntary hospitals in approximate balance is not very large when considered in relation to other things and would not amount to much more than \$5,000,000. The danger is that if costs are not covered the voluntary hospitals will case to function, in which case it will cost the critical agree of the sick in public institutions than it does through the voluntary hospital system.

If this city, like many another, can't take care of its own ailing let it say so But do not let it keep up the pretense that it is doing so when actually it is asking private charity to shoulder half its burden and arrogating the credit to itself

Do not let the average citizen be guilled into thinking that the city or state is taking care of him when it is not. Not when private charity is being bled white.

If there ever was a matter which should become one for public discussion, this is it. If our social system is going to change, very well. If the fountains of private charity are to be exhausted, perhaps that is inevitable. But we can at least put our eards on the table.

We cannot allow our system of voluntary hospitals and our long and honorable tradition of the best care for the sick poor by the best men of the medical profession, unremunerated to be dragged down by the inadequacy of any system of social ized care that hasn't worked well, doesn't work well and probably won't work well

Are we to be forced to abandon a voluntury hospital system which is one of the proudest evidences we can present of the sense of obligation of our well to-do people and be constrained to substitute a municipal or state system of socialized care which will then be pointed out as one of the most recent and most glaring evidences of the failure of private enterprise?

Current Editorial Comment

Cancer and Chemistry—In a recently published editorial, Charles Huggins expresses the opinion that at long last a beginning has been made in the treatment of advanced cancer by chemical means. The tremendous progress in other departments of science, particularly in physics and chemistry, since 1941 has contributed heavily to advances made in the medical sciences Progress in the mastery of disease must go hand in hand with more knowledge of the structure and function of normal tis-

sues and organs. As advances against in fectious diseases in previous decades were made step by step, so now the assault on cancer shows benefits, not along the whole front but only in a few specific types of cumors. In experimental work the use of crude extracts and laboratory soups result in doubt, inaccuracy, and confusion. In vestigators find the greatest rewards in experiments with pure chemicals.

The treatment of cancer is greatly handicapped by the lack of reliable chincal tests Until more dependable tests for cancer are decised it will be impossible to discern the

Nov 1947 Charles: Editorial, Surg. Gynec. and Obst.

slight or minute benefits (or harm) following the administration of any given therapeutic agent. At present the only valuable clinical tests of neoplastic activity are those for tumors of the blood-forming organs and for cancer of the prostate. Rapid and reliable information concerning the presence and extent of cancer is available from an examination of the circulating cellular elements in the blood in neoplasms of the hemopoietic tissues, and by determining the values of serum phosphatases in cancer of the prostate

Chemical agents that seem to have some inhibiting effects on the growth of cancer may be divided into three groups necrotizing agents, competitive inhibition, and nuclear damage

Necrotizing agents It has long been known that the products of certain bacteria, when administered parenterally, produce severe hemorrhage in the tumors within a few hours, with subsequent necrosis of malignant neoplasms. In a brilliant series of investigations, Shear and his coworkers have succeeded in separating the hemorrhage-producing agent in a culture of Serratia marcescens (Bacillus prodigiosus) from the toxic and mert contaminants Unfortunately, the necrosis is seldom complete and while some tumors regress, others usually remain viable Further experiments with this more purified and powerful polysaccharide are necessary to determine its usefulness, if any, in the treatment of cancer/

Competitive inhibition In cancer of the prostate, an essential for the nutrition of the malignant cells often is androgen androgen supplied in adequate amounts, the tumor grows vigorously Conversely, the cells tend to wither when androgen is withheld (orchiectomy), or when estrogen is administered Aside from radioactive chemicals, the first agent of known chemical composition favorably to influence widespread cancer was estrogen Also it was the first substance known to exert this effect when given by mouth Both estrogen and orchectomy may be regarded as nonspecific chemotherapeutic agents

In male and female mice, compound E of Kendall, derived from the adrenal cortex, causes massive involution of lymphosarcomas. White and Dougherty have demonstrated that adrenal stimulation decreases the activity of lymphoid tissue. These

biochemical observations are supported by the fact that 11-dehydro-17-hydroxycorticosterone has damaging effects on lymphomas

Para-aminobenzoic acid is a substance essential to the growth of certain bacteria. The ability of sulfonamides (demonstrated by Wood and Fildes) to neutralize these beneficial effects of para-aminobenzoic acid is an illustration of competitive inhibition.

Nuclear damage The injurious effects of irradiation on tissue cells, including the frequently observed mutations, are probably the action of the rays on the nucleic acids of the cell nucleus Radioactive isotopes with a short period of decay may be used to apply soluble radioactive chemicals to tissues throughout the body Huggins believes that "radio-active phosphorus has great value in chronic lymphatic and myelogenous leukemias and is probably the best therapeutic agent available for polycythemia vera"

Since Lushbaugh demonstrated that the lymphocyte count of rabbits was reduced by the use of nitrogen mustards (B-chloroethyl amines), they have received systematic biochemical investigation. In some cases of Hodgkin's disease, regression has followed the therapeutic use of nitrogen mustard. Aside from those produced by radiant energy, the nitrogen mustards are the only agents known to produce mutations chemically.

Another drug capable of producing regression in cancer growth is ethyl carbamate (urethane) It delays cell division without great interference with respiration Recently it has been shown that urethane reduces the growth of prostatic cancer, particularly those in relapse after treatment with hormones Since this toxic drug acts by pycnosis and is not antiandrogenic, it is a new weapon involving a new principle in the treatment of advanced cancer

We suggest restraint of undue enthusiasm over optimistic reports of the results of chemotherapy in cancer. Aside from the conservative use of endocrines, it is well to remain critical and skeptical of results claimed for drugs having the power and potential dangers of necrotizing agents, radioactive isotopes, the nitrogen mustards, and urethane. Years must pass before these dangerous drugs can safely be used except in experimental laboratories and in clinics under strict control.

Scientific Articles

FATAL HEMORRHAGE ASSOCIATED WITH THE THIRD STAGE OF LABOR

A Study of 60 Maternal Deaths, Brooklyn, 1937-1947

MORRIS GLASS MD, and ALEXANDER H ROSENTHAL MD Brooklyn New York

(From the Brooklyn Committee on Maternal II elfare)

IN RECENT years hemorrhage has been pro-1 jected into the limelight as the major cause for maternal mortality Gordon was one of the first to show its important role, a conclusion reached after studying the deaths in Brooklyn from 1937 through 1941 1 He analyzed the figures released by the Bureau of Records and Statistics of the City of New York and showed how the statistics frequently concealed the true aignifi cance of hemorrhage. When infection or toxemia was given as the principal cause it was duly recorded on the death certificate Hemorrhage was often not mentioned or, if so was considered as an associated cause by the statisticians and was not tabulated Statistical preference in bemorrhage deaths was given to infection, toxemia, cesarean section, embolism, and abortion Further, some deaths assigned to nonpuerperal causes were actually the result of hemorrhage For example, the deaths of two patients from hemorrhage and shock, one after postpartum hemorrhage and the other after rupture of the uterus, were attributed to syphilis because of positive serology The revised statistics clearly showed the prominence of hemorrhage (see Table

This report includes for the most part deaths in which hemorrhage was listed as the primary cause. There were an even greater number during the same period in which hemorrhage contributed heavily to the mortality though not classi

TABLE L-MATERIAL DRATES IN BROOKLYN

	1937-1941		
Official statistics Gordon a revised statis- tics	Infection 124	Toxemia 81	Hemorrhage 81
	112	74	118

Premaied at the 141st Annual Meeting of the Medical Society of the State of New York, Buffal Section on Obbrica and Cynecology May 7 1947

fied as the principal cause. The Brooklyn Committee on Maternal Welfare studied 126 maternal deaths in 1938. In 21 cases, or 17 per cent, hemorrhage was cited as the primary cause of death And yet in 40 per cent of the remaining 105 cases, the blood loss was sufficient to warrant treatment and thus contributed to death. Similar studies in other years revealed essentially the same in eidence of hemorrhage

That this experience is not unique to Brooklyn is shown by other reports. A study from the Province of British Columbia from 1941 through 1943 indicated that the number of maternal deaths from hemorrhage were 42, infection, 28, and tovemia 22 2 Davis and Grady reporting from the Chicago Lying In Hospital stated that infection is rapidly disappearing as the major cause for death" and indicated that hemorrhage is playing the principal role 3 Moreover, a comparative study of maternal mortality in the United States for 1940 and 1942 clearly showed the greatest reduction in maternal deaths from infection while homorrhage deaths were only slightly decreased.4 It is generally agreed that the factors responsible for reducing deaths from infection are better obstetric care, chemotherapy. antibiotics and more frequent use of blood transfumons. It is clear, then, that the major problem in further decreasing maternal mortality lies in the prevention and treatment of hemorrhage

For the past ten years all maternal deaths in Brooklyn have been reviewed by the Brooklyn Committee on Maternal Welfare. A survey of these records affords valuable maternal for study, even though the incompleteness and inadequacy of some reports must be recognized. A few were not available. However, the majority were acquired for screening and represent the true picture. Any omissions we believe will not after the conclusions.

Our study is limited to a critical survey of fatal hemorrhages associated with the third stage of

المحوسية

labor arising from uterine atony, retention of placental tissue and inversion of the uterus will include, briefly, placenta previa cases which died from postpartum hemorrhage, since a study of this complication is in progress Deaths from rupture of the uterus have already been analyzed and consequently are excluded from this report 5 Deaths from hemorrhage and shock following cesarean section are not included except those associated with massive postpartum hemorrhage There are many other section deaths from moderate hemorrhage associated with operative shock These fatalities are principally and anesthesia hemorrhage deaths and constitute an important problem in themselves

The major causes of death from 1937 through 1945 are noted in Table 2 These revised statistics have already been published and clearly illustrate the role of hemorrhage 167

TABLE 2 —Maternal Mortality in Brooklyn from 1937-19451,67

	1937-1939	1940-1942	1943-1945
Infection	84	53	46
Toxemia	56	40	28
Hemorrhage	70	78	122

Material for Study

The causes for hemorrhage in these 60 cases were atony of the uterus, 40, retention of part or all of the placenta, 12, inversion of the uterus, 5, and varied causes in 3. The following data were noted and evaluated

- 1 Predisposing factors
- 2 Methods employed in delivery of the fetus
- 3 Management of the third stage of labor
- 4 Means employed to control hemorrhage
 - (a) Oxytocics
 - (b) Uterine manipulation
 - (c) Uterovaginal pack
 - (d) Hysterectomy
- 5 Blood transfusions
- 6 Time of death in relation to the hemorrhage

Twenty-one additional cases of placenta previa which died of postpartum hemorrhage are included A more detailed analysis appears elsewhere

Atony of the Uterus (40 Cases) —This complication was present in two thirds of the cases. In 24 of these predisposing factors were obvious. Ten were associated with premature separation of a normally implanted placenta, in each of 3 cases fibroids or gross mismanagement of the third stage of labor were responsible, in 2 cases an overdistended uterus or prolonged labor contributed to the atony of the uterus, while in 4 of the cases the factors were varied. These cases

which illustrated predisposing factors were as follows

Case 1—A 34-year-old, white gravida IV, para III, was admitted at term and in labor After fortyeight hours the cervix was fully dilated and within ten minutes she delivered an 8 pound 13 ounce fetus The placenta was delivered within spontaneously a short time, when one ampule each of pituitrin and ergotrate were given Vaginal bleeding was profuse and persisted despite vaginal packing Examination by a consultant revealed a fibromyoma, the size of a lemon, protruding into the uterine cavity continued in spite of a uterovaginal pack. One and one-half hours later the patient was in extremis and was transferred to the operating room for hysterectomy Thirty minutes later, after receiving only 200 cc of blood, the patient died before the operation was started

Case 2—A 30-year-old white gravida V, para III, who had had two previous cesarcan sections, was admitted for elective section. The operation was done under gas oxygen ether anesthesia. Dense adhesions were encountered. The placenta was firmly adherent and was difficult to remove. The patient bled profusely, and it was estimated that between 1,700 and 2,000 cc of blood were lost during the fifty minutes of operating time. The patient expired thirty-five minutes after the operation was completed, without receiving any blood.

Case 3 —A 31-year-old white gravida II, para I, was admitted to the hospital at the thirty-third week of gestation because of marked enlargement of the uterus, causing respiratory distress Although labor began spontaneously, the contractions were weak and meffective The membranes were artificially ruptured, and 8,000 cc of fluid allowed to The contractions then became stronger, and by low forceps under gas oxygen ether anes thesia, the patient was delivered of a macerated stillborn weighing 7 pounds 13 ounces The placenta followed soon afterwards The uterus contracted normally, then relaxed, and from this point until death, six and one-half hours later, the hemorrhage was not controlled Treatment included oxytocics, uterine manipulation, uterovaginal packing and 2,000 cc. each of blood and plasma given in transfusion sanguination far exceeded blood replacement

The methods employed in delivery of the fetus are recorded in Table 3

TABLE 3 -METHOD OF DELIVERY

Spon taneous 19 10 3 1	15 1 1 1		Cesarean Section 4 0 0 1
- 00	18		
	taneous 19	taneous Forceps 19 15 10 1 3 1 1 1	taneous Forceps Extraction 19 16 2 10 1 1 1 3 1 1 1 1 0

Delivery of the placenta in this group was remarkable only because it occurred in six of the vaginal cases more than one-half hour after deliv-

ery of the child Three required manual removal Both of the following cases illustrate the role of general anesthesia in accentuating uterine atony, and, in addition, illustrate mismanagement of the third stage of labor

Case 4.- A 30-year-old white primipara with uterine fibromyomata was admitted at term and in labor. After seventy two hours of labor with the cervix incompletely dilated multiple Dührssen s incisions were made under general anesthesia. Manual rotation of a persustant occipitoposterior was performed followed by forceps extraction. cervical incisions were repaired with the placenta still retained Continuous bleeding from the uterus occurred during this time. The placents was manually removed two hours later and the uterus packed with gauze. The record indicated that the cervical incisions were resutured, probably having been durupted during the intrauterine manipulation The patient went into shock. Treatment included 3 repeated packings and 2 Intrauterine injections of pitultran. The patient died two hours after delivery with only 750 cc. of blood given.

Case 5 -A 32 year-old white primipara was admitted at term. Labor was characterized by utermo inertia. A general anesthetic was given in prepara tion for delivery Examination showed the cervix to be incompletely dilated and so the patient was returned to bed. Later Dührssen s incisions under general anesthesia were performed because of the failure of complete cervical dilatation. The head was manually rotated and the fetus delivered with axistraction forceps. With the placenta in situ and the patient under continued anesthesia, the cervical and epenotomy wounds were repaired. She bled during this procedure. The placenta was then delivered apontaneously Hemorrhage continued and she died one hour and forty-five minutes after delivery

Although the records were often incomplete concerning the use of general anesthesia (Table 4), we regard it as a most important contributing factor to hemorrhage and shock. Local anesthesia has long been favored in our hospital because it permits completion of the third stage and penneal repair without any further general anesthesia.

with no transfusions having been given.

TABLE 4.—AMERITARIA

Atony Retention of placental times Layerlon Miles Haberton	General 13	Lorsi 8	Spinal 1	No Mention 23
Investigated places		0	0 0	7 2 1
	23	ž	1	23

Ten patients with premature separation of a normally implanted placenta died of postpartum benormage superimposed on antepartum or intrapartum bleeding All were inadequately treated. Neither effective conservative therapy nor cesarean section was performed in any case Only 2 received oxytoeics prior to delivery. Six were delivered spontáneously, 3 by forceps and 1 by breech extraction. Despite massive blood loss in every case, only 4 received transfusions and in 2 the quantity given was small. One received a large volume of blood while the remaining one was not transfused until she was in irrever sible shock. Packing of the uterus was performed in 8 cases and in half the vagina was also packed All the patients died from hemorrhage and shock within six hours after delivery and 4 of these died within two hours.

Retention of the Placenta —There were 12 fatal hemorrhages associated with retention of pla cental tissue. Five patients died with the pla centa completely retained Brief abstracts are as follows

- 1 The delivery was done at home by a midwife, and the patient admitted to the hospital in shock after severe hemorrhage Death occurred with the placenta retained
- 2 The ambulance surgeon found this patient dead at home The baby had been delivered without attendance and the placenta was retained The floor was covered with blood
- 3 Delivery took place at home without attendance The patient was admitted to the hospital in irreversible shock with the placents retained. Death occurred in less than one hour
- 4 Normal spontaneous delivery took place in a hospital The patient was transferred to her bod with the placenta retained and with no sign of separation She was found dead in bed from hemorrhage thirty-six hours later
- Rapid spontaneous delivery took place There was an uncontrolled profuse hemor rhage five minutes later Death occurred within an hour with the placenta retained

Seven patients had retention of part of the placenta. Three had spontaneously delivered a placenta which was presumed to be intact. In one patient ten days elapsed before the fatal hemorrhage occurred Manual removal of the placenta had been performed in 4 cases two with great difficulty. It was obvious that incomplete removal caused the continued hemorrhage in all cases.

Inversion of the Uterus —This serious complication occurred in five patients Traction on the cord and/or fundal pressure were the obvious causes in four cases. In the remaining case the inverted uterus appeared at the introitus following expulsion of the placenta The inversion was immediately recognized in three patients Reposition was attempted in two and thought to be successful Hemorrhage and shock continued and further examination revealed the persistence of the inversion

Case 6 -A 20-year-old primipara was admitted to the hospital at term and in labor Under chloroform anesthesia a fetus weighing 3465 Gm was The placenta was despontaneously delivered livered twenty-four minutes later by "gentle traction on the cord without any pressure on the fundus" The blood loss up to this point was estimated at 300 cc. About five minutes after the expulsion of the placenta, the patient went into shock, although the continued bleeding did not seem to be sufficient The fundus could not be felt to account for it suprapubically, and pressure in this area caused in-Treatment included pituitrin, creased bleeding Trendelenburg position, intravenous glucose, heat, and caffeine and sodium benzoate A consultant examined the patient one hour and fifty minutes later and found the fundus to be inverted to the level of the introitus. Under ether anesthesia the inversion was corrected and this was followed by cessation of the bleeding She died two hours later four hours after delivery of the placenta, without receiving any blood

Autopsy showed visceral evidence of evsanguination The uterus was not ruptured and was in nor-

mal position

Case 7 —A 26-year-old white gravida II, para I. was admitted to the hospital at term and in labor The patient delivered spontaneously under open drop ether anesthesia Because of a bleeding third stage, the doctor attempted to remove the placenta by traction on the cord and pressure from above During the process the cord ruptured and now the placents was visible in the vagina Manual removal of the placenta from the inverted uterus was performed with difficulty The organ was "reposited," and a pack introduced into the "uterus" and the vagina Bleeding continued through the pack. A consultant was called who advised expectant treatment since the "inversion had been corrected." Twelve hours later the patient was in shock second consultant advised immediate hysterectomy The uterus was found to be inverted, although elevated into the abdominal cavity by the vaginal pack.

The inverted uterus was first corrected and then extirpated. Postoperatively, the patient received three 500 cc blood transfusions, causing a marked improvement in her general condition. However, two days later the urine showed pus cells and 4 plus albumin. On the following day anuma was noted, and this condition persisted until death from uremia on the fifth postoperative day. In all probability this complication resulted from incompatible blood, since cystoscopy revealed both ureters patent.

Case 8—A 20-year-old white primipara was admitted at term and in labor Delivery was performed by low forceps under gas-oxygen anesthesia Five minutes later, the placenta was noted bulging from the introitus and was expelled spontaneously by the

Duncan method A reddish, ragged, pear-shaped mass, recognized as an inverted uterus, appeared at the vulva. It was promptly "reposited," and a vaginal pack introduced Bleeding persisted The pack was removed, and according to the record the inversion of the uterus was now corrected thirty minutes after delivery A transfusion of 500 cc of blood was given within two hours and the patient rallied An hour later the patient went into shock and was given intravenous glucose solution, coramine caffeine and sodium benzoate, adrenalin, but no further blood transfusion. The patient died from hemorrhage and shock six hours after delivery.

Case 9—A 29-year-old, white gravida IV, para III, seven months' pregnant, delivered the baby before the ambulance doctor arrived. The placenta was retained. The doctor failed in his attempt to express the placenta. Fifty-five minutes later the placenta was delivered by a modified Credé maneuver and the uterus was inverted. The patient was hospitalized in shock with the uterus inverted, and died one hour and twenty minutes after delivery. No transfusion was given

Case 10—A 23-year-old white primipara was admitted at term. After thirteen hours of labor, the cord prolapsed, and delivery was completed by breech extraction. The placenta was expressed. Two and one-half hours later profuse bleeding occurred, and the patient went into shock. The patient received 1,100 cc. of blood, recovered from shock, bled again two days later, and again went into shock. At this time the fundus could not be felt suprapulically, and vaginal examination showed an inverted uterus. The patient received 1,500 cc. of blood before the inversion was corrected surgically. The patient died three days later of sepsis.

Miscellaneous Cases —There were 3 miscellaneous cases One of particular interest is as follows

Case 11—A 32-year-old, white gravida III, para II, was admitted to the hospital at term — Fourteen hours after admission with the cervix fully dilated, an ovarian cyst was found obstructing the head Laparotomy was performed and a dermoid cyst removed — Vaginal delivery was accomplished by forceps, and the placenta was expressed — The patient died three hours later from shock without appreciable external bleeding — No transfusions were given. The cause of death was slipping of the pedicle ligature

Deaths from Postpartum Hemorrhage Superimposed on Antepartum and Intrapartum Hemorrhage in Placenta Previa—Fifty deaths from placenta previa occurred during the ten-year period covered in this study and will be reported elsewhere. Twenty-one patients died from postpartum hemorrhage, 2 following cesarean section, and 19 after being treated vaginally. In the latter group 8 had clinic evidence of rupture of the uterus, although in only 2 cases was rupture actually diagnosed, either by palpation or at autopsy.

The increased likelihood of postpartum hemorrhage in placenta provis and the rationale for it have been discussed in obstetric textbooks. When the placenta is largely implanted in the lower segment, its separation may be retarded and im paired by the failure of the lower relaxed portion of the uterus to contract as effectively as the upper portion Moreover the lessened contractions and retractions of the lower segment may bring about meffective hemostasis of the large blood mauses, formed here as a result of the previa. It has also been suggested that postpartum hemor thage in placenta previa is due to small unrecog mied lacerations in the highly vascular lower segment rather than to abnormal muscular con tractions *

Time of Death. (See Table 5) Forty-one patients died within five hours. 29 of these were dead in three hours. All but three of the remain ing expired within 15 hours. Two of the three remaining patients died from sepsis several days after delivery In the remaining case retention of part of the placenta caused a fatal hemorrhage 10 days after delivery The rapidity with which these patients died was strikingly in accord with Beecham's report of hemorrhage deaths in Phila delphia. He noted the average time between delivery and death to be five and one-half hours It is obvious then that obstetricians must recog one predisposing causes for hemorrhage, and be prepared to deal with them adequately Moreover, they should have a defense ready for patients who bleed unexpectedly

TABLE 5 .- Time of DEATH FOLLOWING DELIVERY

Atma	Up to 3 Hours	8-5 Hours	5-15 Hours	Longer
Atony Retration of Discental sizes	19	8	13	0
placental three	. 5	3	2	2
Missellaneous	3	ī	ĩ	O
налеона	2	0	0	1
	-		_	-
~	29	12	16	8

TABLE 6.—Blood Transpurious

None Insternate Adequat	1937 1939 14 8 1	1940-1942 8 6 7	1948-1945 9 8 5	Total 28 19 13	•
	23	18	19	60	

Blood Transfusions —Only 13 patients received adequate amounts of blood (see Table 6) Insufficient quantities were given in 19 cases, while 23 patients received no transfusions at all. Thus, 50 per cent of the cases received either no blood at all or insufficient amounts. Since 41 patients dued more than three hours after the hamor rhage, there is justification for the inference that there was time enough for transfusion.

Whole blood is the only substitute for blood loss. To avoid delay all patients should be typed and Rh'd during their prenatal course. Moreover, the recognition of the Rh factor makes transfusion less feared from reactions litherto un explained. Rh negative type O blood of low titer should be on hand in all maternity hospitals and should be employed to combat exanguinating hemorrhages while cross matching is being done. At the very least, plasma should be given in such emergencies as a temporary expedient.

Pack and Hysterctomy—(Table 7) Vagual and/or uterine packs were unsuccessfully employed to control hemorrhage in 36 cases. The uterus, alone or in combination with the vagual was packed in 31 cases, and even in some repeated packings were employed.

TABLE 7 -- PACK

	Vaginal	Uterino	Combined	None
Atony Retention of	1	13	14	1
placental thank	2	2	1	7
Inversion	3	ō	Ō	8
Miscellancous	υ	1	D	3
	5	16	15	24

Obstetric textbooks recommend the use of a uterine pack to control bleeding, provided more conservative measures fail. Despite this statement there has been a growing tendency to discourage its use in Brooklyn. At a recent meeting of the Committee on Maternal Welfare few would defend its use in a pertinent case under discussion at that time.

We believe there is a definite place for the pack. If a patient experiences a severe postpartum liemorrhage from an empty atonic uterus which fails to respond to massage oxytocics intrauterine pressure and abdominal manipulations few would standidly by and withhold the use of a pack

There are two reasons for the failure of a pack to control hemorrhage. The first is an incorrect diagnosis of the underlying cause of hemorrhage. In the presence of a lacerated cervix or uterus, or with retention of placental fragments, hemorrhage cannot be controlled by the pack. Packing the uterus of a patient in irreversible shock is often futile, for the organ may fail to contract and retract. Excessive blood loss causes anoxia and tissue damage, and such alterations within the myometrum may contribute to atony

The second reason for failure is faulty technic. Uterine packing is ineffective unless a firm, molst pack is introduced to the fundus, and the entire cavity is packed layer by layer with no intervening spaces remaining to favor the accumulation of blood. This is best done under general anesthesia. Perhaps the greatest value of the pack lies in reducing the blood loss while the operating

room is prepared for hysterectomy. Repeated packings are inadvisable, particularly if the above factors have been taken into account. Hemorrhage which is not controlled with one pack is not likely to respond to another, and precious time and blood are lost.

Five patients had hysterectomies in a valiant attempt to control the bleeding but were already in irreversible shock at the time of operation. A uterus, failing to respond to all the accepted methods of treatment, should be extirpated rapidly, while the patient is receiving large amounts of blood. Analysis of these 60 cases indicates that many of these patients might have survived, had this procedure been used early enough.

Management of the Third Stage of Labor — Analysis of these records indicated great difficulty in determining the factor of mismanagement of the third stage of labor in causing the fatal hem-It was clearly a major factor in many Thus, the 12 cases of retention of all or part of the placenta fitted into this group 5 cases of inversion of the uterus were also examples of mismanagement In some of the patients in the atony group the placenta was allowed to remain in the uterus for more than an hour despite a blood loss exceeding 1,000 cc group there were also instances of continued general anesthesia while lacerations or episiotomy wounds were being sutured with the placenta in situ Furthermore, some patients were removed from the delivery room with the placenta completely retained, and while in bed, unattended. suffered a fatal hemorrhage Still another factor was the retention of part of the placenta, although the doctor had been of the opinion that the placenta had been delivered intact In cesarean sections the placenta was only casually examined, if at all, before the uterus and the abdomen were closed It becomes evident, then, that the proper conduct of the third stage of labor is the best prophylaxis against hemorrhage

It may not be amiss to recapitulate the management of the placental stage, the stage in which hemorrhage is the great hazard. One must recognize any predisposing cause for abnormal separation and expulsion of the placenta Conditions which must be prevented or, if present, recognized, are as follows excessive and prolonged use of analgesia, inertia caused by overdistention of the uterus due to (a) multiple pregnancy, (b) large baby, and (c) hydramnios; tumors of the uterus, i.e., fibroids, placenta previa and ablatio, history of previous abnormal third stage, operative trauma (Beecham called particular attention to this factor³), long, general anesthesia, full bladder, and pre-existing anemia

Signs of placental separation must be awaited before any abdominal manipulation is attempted since premature expulsion of the placenta may initiate bleeding from partial separation arbitary period of time need be set in awaiting spontaneous separation of the placenta in the absence of bleeding, as long as the obstetrician remains with the patient, and the patient remains in the delivery room. Under no circumstance should a patient leave the delivery room with the placenta retained The majority of obstetricians feel that if one hour has elapsed, and signs of separation are absent, manual removal of the placenta under general anesthesia should be done if Credé expression fails The difficulties and hazards of this procedure have been exaggerated

The technic employed in expressing a completely separated placenta is important uterus should be stimulated to contract No attempts at expulsion should be made while the uterus is relaxed since this may cause inversion of the organ Four fingers of one hand with the thumb anteriorly grasp the fundus The force is directed toward the birth canal, using the contracted segment of the uterus as a piston cord must not be pulled upon, since this too might cause inversion, especially if fundal pressure is applied while the uterus is relaxed placenta appears at the introitus, the uterus should be lifted up and out of the pelvis by placing four fingers behind the pubis and directing the force upwards The contracted fundus is then gently massaged It is our routine to administer one ampule of ergotrate intramuscularly at this time

Estimated blood loss during the third stage is notoriously unreliable. When precise determinations are made, it is found to be far in excess of the amount estimated. Accordingly, in the presence of a bleeding third stage, when Credé expression fails, manual removal must be prompt. The uterus should always be re-explored for placental fragments or uterine lacerations. Placenta and membranes should be carefully inspected to be certain that no cotyledon or succenturiate lobe has been left behind.

Bleeding following complete expulsion of the placenta and membranes is due either to atony of the uterus or to lacerations in the birth canal. The latter can be seen, and, moreover, the uterus is firmly contracted. One must be certain that the uterus is completely emptied. It is occasionally difficult to determine the completeness of the expressed placenta. Exploration of the uterus under strict asepsis is advocated to remove any retained fragment.

If the uterus is relaxed or relaxes intermittently, it is then elevated and massaged One ampule of pituitrin is given intramuscularly along with one ampule of ergotrate intravenously If the uterus fails to contract and bleeding con tinues in spite of therapy, then the following procedure is advised the operating room should be prepared, the uterus and vagina should be tightly packed with wet gauze, blood transfu sions, which should have been started already, are continued, and a hysterectomy should be per formed rapidly if bleeding is not controlled

Rupture of the uterus occurs more commonly than is generally realized Of 660 maternal deaths in Brooklyn, 30 or 5 4 per cent were due to utenne rupture This is far greater than the 0.7 per cent incidence reported by Beecham . Rupture must be considered when shock is greater than the estimated blood loss warrants, and uterine exploration should be made. This procedure is recommended routinely after such highly traumatic vaginal procedures as internal version, difficult midforceps and unorthodox breech extraction through an incompletely dilated cervix.

The majority of reports indicated the use of intravenous and subcutaneous fluids and such stimulants as caffeine, adrenalin, coramine and digitals in an attempt to save the patient The statement would frequently read as follows "Despite the above treatment the patient finally succumbed from cardiac failure" Death from hemorrhage and shock is never due to cardiac failure

The need for adequate blood replacement in hemorrhage cannot be stressed too strongly or too often Reliance should not be placed on intravenous or subcutaneous fluids with crystalloids or even on blood plasma Any patient with anteor intrapartum hemorrhage is predisposed to postpartum bleeding and should be cross matched immediately There should always be sufficient blood available for replacement.

Conclusions

- 1 Sixty deaths from hemorrhage associated with the third stage of labor have been reviewed.
- Multiplicity of causes for hemorrhage was noted in many cases. The major factors were atony, retention of placental tissue and inversion of the uterus
- 3 Seven patients had partial retention of placental tissue, unrecognized until fatal hemor rhage Careful inspection of the placenta after

vaginal and abdominal delivery should be routine

- Tive patients died with the placents completely retained Manual removal of the placenta is not hazirdous and when indicated, should not be delayed
- Five cases of inversion of the uterus occurred, four after improper conduct of the placental stage They were generally not recog nized until profound shock intervened
- Prolonged general anesthesia contributed to hemorrhage Local anesthesia should be used more frequently
- 7 The time between hemorrhage and death. though brief was sufficient to effect adequate blood replacement in the majority of the cases.
- The conduct of the third stage of labor has been reviewed. Its mismanagement was obvious in many instances and contributed heavily to the mortality
- The prophylaxis against hemorrhage should include the correction of anemia during the prenatal period All patients should be typed and Rh'd early in pregnancy Compatible whole blood should be available at all times. Blood banks are the best source from which to obtain this whole blood
- 10 Although the pack was used unsuccessfully in 35 patients, it has a definite place in the treatment of postpartum hemorrhage The same is true of hysterectomy
- The use of cardiac stimulants and intravenous fluids in the treatment of hemorrhage is futile. Adequate whole blood replacement is the only proper therapy
- 12 In a group of 50 deaths from placenta previa, to be reported 21 patients died from postpartum hemorrhage superimposed on anteand intrapartum bleeding The cause of this complication has been discussed

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FAILURES IN GLAUCOMA OPERATIONS HISTOLOGIC STUDY

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THE HISTOLOGIC study of eyes, removed after unsuccessful operations for glaucoma, shows that ideal surgical relief has not been devised so far as the laboratory is concerned. In the examination of approximately 100 eyes with glaucoma for an earlier report and in specimens reviewed since that time, at least three universal findings are noted.

- 1 Retention of adhesions between the iris and the corner.
- 2 Fibrotic closure of new filtration channels
- 3 Inflammation of the uvea and fibrous tunic

Adhesions or synechiae between the anterior surface of the iris and the posterior surface of the cornea are composed of such dense connective tissue that permanent separation by operation is almost impossible. The artificial filtration channel or channels become closed by the proliferation of connective tissue, and it makes little difference whether a portion of the iris is included in the operative wound. Inflammation of the uveal tract or progressive iridocyclitis and fear of sympathetic ophthalmia often force the surgeon to admit defeat and advise enucleation.

The operations for glaucoma which illustrate the general microscopic findings of all globes sent to the laboratory are the indectomy, the indencless and the trephine. A study of these eyes shows the following in common

- 1 Edema and bullous changes in the corneal epithelium
- 2 Generalized thinning of the cornea and sclera
- 3 Inflammation at the limbus
- 4 Shallowness of the anterior chamber
- 5 Dilatation of the pupil and adhesion of the iris to the cornea and sometimes to the lens
- 6 Inflammatory changes in the iris and ciliary body
- 7 Swelling of the crystalline lens
- 8 Depression of the optic nerve with atrophy
- 9 Degeneration of the ganglion cells of the retina
- 10 Unusual findings in the vitreous body

A specimen of chronic simple glaucoma not relieved by a cyclodyalisis operation is presented to illustrate the summary listed above (Fig. 1)

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Operations for Glaucoma

The Iridectomy Operation—An eye, demonstrating most of the usual microscopic findings after unsuccessful iridectomy operations, shows generalized thinning of the fibrous tunic with edema and absence of the corneal epithelium. The operative wound is closed by dense connective tissue in which some of the iris pigment remains. The stump of the iris extends toward the center of the cornea and is adherent to it, showing that the synechia is just as extensive as it was before the operation was performed. In other words, the normal iris angle is not restored and the adhesions are not relieved.

Further study of the specimen shows considerable edema and round cell infiltration at the limbus which extends into the operative wound. The cornea is somewhat thinner than normal and the epithelium is undermined in the periphery, swollen and absent over the center. Bowman's membrane is intact except in the region of the limbus, where pannus is beginning to form. A membrane is forming on the anterior surface of the iris, and the endothelium is covered with a thin layer of round cells, fibrin and pigment par-

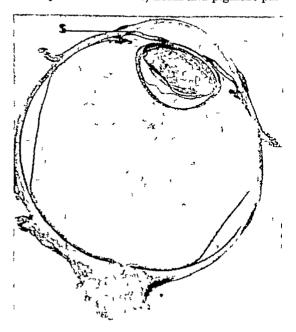


Fig 1 Section of an eye with chronic simple glaucoma after cyclodyalisis operation Anterior peripheral synechiae "S" remain undisturbed

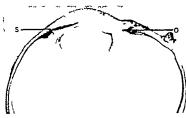


Fig. 2. Iridectomy operation 'O shows stump of iris extending toward apex of cornea and adhesions remaining. Anterior peripheral synechiae S on unoperated side.

ticles. The sclera is thinner than normal and shows little of importance (Fig. 2) The irus is characterized by atrophy, broad anterior periph eral synechiae and chronic inflammation. The ins stump extends far anterior to the filtration angle which has been closed by adhesions The membrane forming on the anterior surface of the uns, and contributing to the adhesions, has firmly scaled any possible connection with the normal drainage spaces. The ciliary body shows atroplus and inflammatory changes, and the choroid is flattened to a mere line by pressure and fixa tion. The retina shows destruction of the gangion cells, edema and cystic degeneration crystalline lens has been removed but its enlarged and forward-displaced capsule remains. A frag ment of ms hes on the anterior surface of the lens. Careful study of this specimen indicates that the iridectomy failed to create a new drain age channel and the synechiae were undisturbed The presence of inflammation contributed to the loss of the eye.

Ins Induston Operation —An eye removed after an unsuccessful tris inclusion operation shows atrophic uveal tissue in the operative wound, shallow anterior chamber, and definite lens changes. The fibrous tunio is distended and thunner than normal The epithelium shows signs of edema and bullous-like formation near the operative wound (Fig. 3)

A more intensive examination of the sections shows that the iris is included in the bleb and that filtration is possible. There is sufficient space between conjunctival flap and the iris for aqueous drainage. Unfortunately, the iris shows agas of chronic inflammation, and firm diagonal adhesions which unite the root of the iris to the base of the flap. Instead of acting as a filtration wick," the iris forms a firm band which dams the aqueous behind it. There is no relief from increased intra-ocular tension which accounts for

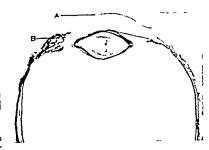


Fig 3 Iris inclusion B' in operative wound Separation of corneal epithelium "A" by bullous formation

distention of the globe and formation of bullae on the cornea

The crystalline lens has moved in the direction of the filtration cicatrix. It is saved from complete dislocation by a firm adhesion of the pupil lary area of the iris to its anterior capsule. The iris itself is almost diamond shaped in cross section and shows evidence of nuclear sclerosis Some of the contraction of the lens cortex is due to hardening agents. Displacement of the lens is a fairly common finding after operations for glau coma.

Most of the inflammatory changes in this specimen are in the vicinity of the operative wound There is congestion of the blood vessels with extravasations into the loose connective tissue. A small hemorrhage lies adjacent to the ciliary body Diffuse lymphocytic infiltration and fi brotic changes complete the picture. The iris on the aide opposite is drawn taut by its adhesion to the displaced lens. It is atrophic and diffusely infiltrated with lymphocytes. The ciliary body shares in the atrophic changes just mentioned

The eventual loss of this eye was due to the bandlike adhesion of the iris across the mouth of the operative wound displacement of the lens, distention of the globe, and bullous keratitis.

Trephane Operations—Eyes enucleated after unsuccessful trephine operations may be explained by the description of a typical 'failure" (Fig. 4)

The specimen shows the anterior chamber to be shallow the crystalline lens swellen and the operative wound closed by fibrous tissue. The cornea is irregular in thickness. The epithelium is slightly undermined by new blood vessels and connective tissue at the limbus. The stroma is moderately infiltrated in the periphery. Descemet's membrane is curied on itself near the operative wound and the endothelium is covered with a thin layer of fibrin. The operative wound is

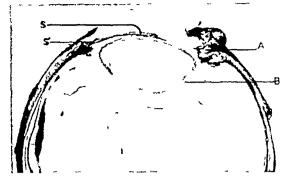


Fig 4 Unsuccessful trephine operation showing trephine wound "A", posterior synechiae "S", anterior peripheral synechiae "S", and crystalline lens "B"

closed by dense connective tissue containing fragments of pigment, lymphocytes, and new The filtering cicatrix contains blood vessels The iris is atrophic and is fresh hemorrhage closely adherent to the cornea and lens on the unoperated side That an iridectomy has been performed is shown by a part of the iris lying in the The ciliary body and the choroid show atrophic changes with congestion of the blood The retina is undergoing degenerative changes with diffuse hemorrhage in its innermost The crystalline lens shows cortical cataractous changes with nuclear sclerosis The lens is in close relation to the filtration wound

The loss of the eye was due to fibrotic changes in the wound and close approximation of the lens. The new channel was blocked and the closure of the iris was not relieved.

Conclusions

- 1 Failure of the indectomy operation may be due to persistence of synechiae and because the iris was not removed at its root
- 2 Iris inclusion operations may be closed by the iris itself
- 3 The trephine operation may become closed by fibrotic and inflammatory changes

Discussion

Harold E Wass, M D, Buffalo—Dr Payne's specimens indicate that the pathogenesis of the failures is subject to individual variations, not only of the eyeball operated upon but also of the ophthalmic surgeon as well

Since the publication of Dr Payne's second contribution to this aspect of ophthalmology, a similar study was undertaken in the Department of Pathology of the Buffalo General Hospital in an effort to ascertain how closely the evidences could be paralleled Although the amount of material studied was smaller, Dr Payne's conclusions were strongly substantiated

Fewest globes were represented in the failures which had some form of iridocorneosclerectomy Pathologic curiosities were not encountered at all, although they do occur It is well to insist on the

pathologic examination of all enucleated globes in order that they may be detected when present, for they will make almost any important intra-ocular operation hopeless, no matter what the precautions This is especially likely to happen if the patient is first seen with tension already greatly increased when there is no time for detailed clinic observation

Early in glaucoma, the pathologic picture is characterized by hyperemia and edema of almost every ocular structure Hyperemia and edema of themselves are considered by pathologists as temporary alterations in tissue structure and function They may subside without resulting in any permanent change of tissue metabolism However, if the process is not releived and progresses to the fixed stage, the tissue changes are irreversible true anywhere in the body but especially true in the eve Other tissue changes are superimposed on these and the final stages exhibit marked alteration in both histology and function. This is why surgery in early glaucoma, from a histologic point of view, should produce the best results. The hyperemia and edema are relieved before thay can pass into more complicated stages

Later in glaucoma, the surgery is not so satisfactory histologically because the degenerative processes are so fixed. Adhesions are broad and firm. The actual formation of new tissue has occurred, usually involving the angle, and the appearance of newly formed blood vessels is known to be a poor prognostic sign.

The failures studied at the Buffalo General Hospital were divided into two broad groups. The first group, those classed as physiologic failures, included globes lost from hemorrhage or infection. The second group was considered to be mechanical failures, for, while the hemorrhage and infection were not present, there was continued hypertension of the globe. The chinical findings in both groups were correlated, and it became apparent that failures of the first group bore no consistent relationship to the type of surgery performed, whereas the group of mechanical failures bore a rather marked relationship to the type of surgery performed, in that the anatomic factors favoring filtration were unsatisfied by the surgery

The importance of the time factor as a cause of failure was revealed in the series at the General Hospital in Buffalo Certain of the eyes, demonstrated by Dr Payne, as well as many in our own series, failed to respond to almost any operative procedure. Clinical investigation revealed that they were all glaucoma conditions which had existed for from five to twelve years in which surgery was delayed or had been advised and was refused.

The importance of Dr Payne's contributions are just as apparent to the ophthalmologist, whose interest is chiefly clinical, as they are to the ophthalmic pathologist. Every histologic change has its clinical counterpart. All these factors will be important when the final decision is made concerning the time for surgery and the type of operation to be performed on an eye with elevated intra-ocular tension.

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THE CONSERVATION OF HEARING PROGRAM IN NEW YORK STATE

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UNDER the title "The Conservation of Hearing Program in New York State," there might well follow a detailed study of the number and variety of hearing difficulties that are to be found within the confines of the state. To this might be added a résumé of the facilities available for the alleviation of these maladies. The statistics for such a paper have been compiled and are a matter of record. This presentation will assume that these facts are well known and do not need repetition at the moment. This paper instead, is a plea for the support of the otolaryn gologists of our society for a new state-wide plan for the solution of some of the hearing problems of our entirers.

The need for such a planus obvious Until now most of us who are otolaryngologists have con cerned ourselves with the care of such hearing ailments as we ourselves can alleviate The disposition of those patients who have irreversible bearing loss is, for the majority of us, a matter in which we have little interest. Or if we have had the interest, most of us have done little about it It is time we did At this point it is quite proper to give credit to those of our number who have been proneers in the field of hearing problems and devoted much of their time and attention to them. Lacking the results of the efforts of these men, some of whom are still active and an example to the rest of us, we would hardly know where to turn for a program. They have set their sights and we can build on their foundations—if we will

I have said that the need for a plan is obvious To personalize the issue and be specific I would like to ask what you say to a patient whom you bave examined and found to have an irreversible hearing loss in both cars of more than 30 decibels in the speech frequencies? Your routine instructions most likely follow this pattern the names of some of the better hearing aid com panies Go to these, try out their aids and select the one best suited to you" I am going to con less right now that until September 1946 some such instruction was my custom. I said that and little more. Last September we started a Con tervation of Hearing Center in Syracuse to which we can refer patients for the trial and fitting of hearing aids. I no longer need to say what I did before. I could elaborate on this, but for the comings. This is not done to chide and scold, for I have been as guilty as anyone here How regularly do you mention the need for lip reading to such an individual as I have described? What do you do to see that such an individual makes contact with such instruction? What do you sug gest for a program of auricular training? Do you make the moves necessary for speech correction when hearing loss is responsible for slovenly speech? These would prove embarrassing questions if I were to ask now for your individual For most of you the real answer to answers these questions would include the information that such facilities as are needed for the solution of the implied problems in the above questions are not available to you and consequently, you do not open the subject.

Recently, through the efforts of the Committee on the Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology there was publicated a practical program for the average otolaryngologist which might be instituted by him in his office for the trial and fitting of hearing aids It was widely distributed, and I do not doubt that each of you read it with interest I did and found that for me it was not practical I do not doubt that most of you came to the same conclusion There is it seems to me. a vital reason why such suggestions have failed in the past to meet with popular approval. The selection and fitting of hearing aids and the institution of attendant remedial rehabilitation measures is something which requires the expenditure of a considerable amount of time Furthermore and this is the crux of the whole matter, the average otolaryngologist is so busy that he cannot devote the required amount of time to do the job, and consequently, he does not do it I think it is time we recognized this important fact, ac cented it, and began to attack this problem on a state-wide basis from an entirely different angle

Aural Rehabilitation

As a result of the war, a new phrase has crept into our terminology—aural rehabilitation. The medical corps of the Army and Navy, early in the period of hostilities, inaugurated a program which was given this name. It is felt by many that this endeavor was one of the best if not the finest, of all the activities of the medical corps of the services. Most of the technics used were known to otologists and allied personnel before their employment in this enterprise. These modalities

before. I could elaborate on this, but for the moment I wish to continue a review of our short

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had been brought into vogue by some of the pioneers previously mentioned But it is fair to say, I think, that never before had all the methods been brought together under the use of such a variety of highly skilled personnel and employed with such effectiveness. The testing of hearing, the trial and fitting of hearing aids, auricular training, speech reading, speech correction, psychologic studies, and vocational guidance were correlated under a single program which brought about a satisfactory rehabilitation to the majority of those who were assigned to these centers a result of a questionnaire sent in 1945 to the rehabilitees of this program, it was found that, of those who were fitted with hearing aids, over 90 per cent were still wearing them after the lapse of more than a year This is a distinct advance over civilian experience and points out the value of a correlated service such as this was of you have visited one of these aural rehabilita-If you have not, you owe it to vourself and your patients to do so The nearest one to New York State is to be found in the Philadelphia Naval Hospital in that city There will soon be, if it is not already in operation, a similar center in New York City under the auspices of the Veterans Administration The record made by these centers is too significant to ignore

Recognizing that, individually, otologists cannot furnish adequately the service required for amelioration of this aspect of the hearing problem, it has seemed to some of us that it would be wise if we could adopt some of the features of the aural rehabilitation program of the armed forces and use them to meet the need which faces us in New York. If this were done, centers might be established in a dozen or more strategically located cities throughout the state and be so placed that no person who might need their services would be too great a distance from one of them. As these centers proved their worth, they could be enlarged in staff or in number until the requirements of the populace were met.

Civilian Centers

These civilian centers would not need all the elaborate equipment, nor all of the personnel of the military groups This would eliminate some of the elaborate service rendered the veteran, but, with a great saving in expense, the essential features could be retained Each center should be under the direction of an otologist this leadership there should be personnel trained in audiometry, speech reading, speech correction, auricular training, and the trial and fitting of hear-A few such workers are presently availing aids Courses given in several universities will soon make available others who can be secured to work on such a staff The number needed

would depend on the case load A minimum for such a center would be one otologist, one (to give a name) audiologic technician, and a social worker-secretary A complete staff would include two or more otologists, several audiologic technicians, an acoustic engineer, a psychologist, a vocational counsellor, a social worker, and one or more secretaries Such a large staff as this would be required only in the metropolitan districts A certain amount of equipment would be needed Space is an essential, including one or more soundproof rooms In addition, there should be enough instruments for a proper examination of the ears, nose, and throat should be added two audiometers, tuning forks, and other diagnostic aids A radium applicator should be included A typewriter and secretarial appurtenances would complete the essential equipment

It must be recognized and mention made of the fact that there are several such civilian centers in operation in the state under private auspices These have been in successful operation for some years and have proved their worth beyond ques-But it should also be noted that these are principally located in New York City where the above mentioned pioneers have enthusiastically pleaded their cause and have raised the necessary funds for the establishment of their clinics With the exception of Albany and Rochester, none of the other major cities of the state, to my knowledge, have embarked on such endeavors, and, consequently, much of the territory and a large part of the populace is unserved. If I have omitted any worthy local endeavors, it is due to my ignorance of them and not to intent

The mere outline of the personnel and equipment needs of such centers, as sketchily outlined above, brings to mind at once the fact that finances will be necessary to establish and maintain them If such a program, state-wide in scope, is to be inaugurated, how can this need be met?

I would suggest that existing facilities and services be utilized Most cities of any size have an outpatient clinic or free dispensary which would willingly house a center already in the employ of such a dispensary might be utilized at little additional expense taries and social workers might thus become immediately available An otologist on the staff of such an institution could be interested, and the addition of an audiologic technician or two would be all the additional personnel which would be The examining equipment of the dispensary could be used, so, in the main, all the additional requirements could be met by the building of a soundproof room, the purchase of an audiometer or two, and the procurement of a sufficient number of council-accepted hearing aids

for trial. The latter can be secured from the hearing aid companies without cost with the exception of one or two of these companies. Not all communities might be this fortunate but most would, and if so the main expense of such a center aside from the non recurring item of the mital equipment, would be the subaries of the audiology technicians.

Knowing the inertia of most communities toward the acquisition of additional annual expense items, such as audiologic technicians ralaries, your New York State Medical Society Committee for the Hard of Hearing and the Deafened has met several times and discussed ways and means by which provision may be made to meet such expenses. It has been felt by most of this committee that if public funds could be secured to cover these items, it would not be long before the state could be manned by a network of hearing centers. On the contrary it was felt that if it were necessary for each community to find means by which these charges could be met it would in all likelihood, be a matter of years before such a worthwhile and needed program could be established With this thinking in mind, several conferences have been held with officials of the State Health Department and State Rehabilitation Services It is not necesmry here to detail the delays which have occurred, postponing a hoped for favorable answer from these sources. Failure to receive funds from such suggested sources should not prohibit or even postpone this contemplated endeavor Funds from some source will be available, I am sure, for such a worthy cause It remains for us to uncover it, and then get to work

In the nebulous state of this program, no name has been given to these proposed clinics. I would respectfully suggest they be called Conservation of Hearing Centers. This is a positive program. Hard of Hearing Clinics or tren Hearing Clinics would not have the same

connotation and appeal

What can be accomplished if such a program is established? In the first place there would be a place in strategically located communities to which any person with impaired hearing could go and receive a competent examination, approprate medical and surgical treatment and, if the latter was not indicated rehabilitation measures which would insure to the individual a more useful poution in society There would need to be only a few locations where the greatest distance to be traveled to reach such a center would be more than 50 miles It may be argued that even this is too far to expect one to go for such help If this proved in practice to be true it is possible that traveling centers might be established Time would tell on this score. However the centers would be available, and we as otolaryngologsts, would not have the feeling of ineptitude which is ours when we say, in essence, to a patient "Go and find your own hearing aid and get along the best you can with it"

There is no reason why private patients with ability to pay for such services should not attend these centers. Their initial examinations and diagnoses could be made by the otolaryngologist of their choice and the decision made by him that a hearing aid was advisable. Payment for services rendered by the center would not be taking money from the doctor, for, save in very exceptional instances, he would have no further service to offer

Such a trend could and would have a deterrent effect on the rank commercialism which now surrounds the selling of hearing aids Some education would be necessary at first, but it would soon become known that facilities for the trial of aids was available to both poor and rich alike, and that in this trial because no aids would be sold or no rebates accepted, the commercial element would be eliminated. This would eradicate many of the grossly erroneous statements which are now made by many of the hearing aid salesmen. Recently the mother of a doctor came to my office to ascertain what she should do to be properly fitted with an aid She had visited one company, and its representative had told her that it was my custom to send all of my patients She then went to another company and its representative had told her the identical tale She came to me with this statement they both could not have been telling the truth ' It is this type of falsification which I feel could be stamped out by such centers or if not stamped out then greatly curtailed.

Such a program would stimulate interest in the broader aspects of the hearing problem among the otolaryngologists. A state-wide effort properly functioning could not help but be impressive and instructive. It might cause us to realize that this is the problem for all of us and not the problem for a few.

The really significant contribution which could be made by the adoption of such a program would be the enhancement of the welfare of the individual with impaired hearing. We must come to the acknowledgement, if we do not recognize it now that these people are not fully served throughout the state. In some localities yes but in large areas no. They deserve and need the help which such a program would render

It is significant that several states have adopted programs for the conservation of hearing not necessarily similar to the one presently advocated and are in the pursuit of their goals. Many of these are significantly successful. The Empire

State, the richest in the union, is without adequate measures to meet the wants of its people in this regard. As a group, we otolaryngologists should band together to urge measures which will put us not only in the running but in the van The final program may not be what I have proposed, but, whatever it may be, we should be active propagandists for its adoption and enthusiastic supporters of it when it has been adopted I urge your interest in such a goal

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Discussion

Harry K Tebbutt, Jr, MD, Albany—Dr Hoople's paper is most timely and is a challenge to us all to go out and get busy. The responsibility for the care of these patients is surely right in our own laps, and I believe that it is certainly our duty to follow through and not let these patients drift about aimlessly and be exploited by many unscrupulous persons. We have all seen this happen many, many times and, as much as we disliked it, we apparently were unable to control it

In Albany in 1941, we organized a Conservation of Hearing Center, the first of its type to be organ-

ized in upstate New York.

At first we saw these patients in our regular ear, nose, and throat clinic, but soon found the arrangement unsatisfactory because of the noise and con-Therefore, we saw them after the regular patients when more quiet prevailed As the load increased, however, we found it necessary to transfer the other patients to another day and to see only hearing cases in this clinic We are now running 12 to 25 patients a morning and find this number about all we can handle for a thorough work-up, especially if aids are to be fitted Each attending man of the ear, nose, and throat group serves six months in rotation, and is assisted by our resident, assistant resident, an intern, and a group of fourth-year medical students

We rotate the attending men because none of them want to be left out of it, and the resident staff strongly resents any duties which keep it from attending the clinic By having the students attend, we feel we arouse their interest in the subject so that when they go out into practice, they will realize what is going on in this field and what can be done for the hard of hearing

We have been most fortunate in having as a member of our staff, a Miss Pauline Winkler Miss Winkler is a well-trained and exceedingly able teacher of a class of hard of hearing children in one of the city schools. She became interested in the project and encouraged us to start such a center to assist her in her problems with her students. She has worked with us for over six years as a volunteer

The Albany Hospital has provided all the necessary instruments for examining patients, including an audiometer and a relatively soundproof room. A radium applicator is also available for use

We make our own ear molds and seem to have no difficulty in having two or three hearing aid men come to the Center when we have patients to fit. The patients try two or three of the aids, and we help them to select the one which appears to suit them best. These patients return repeatedly for instruction and guidance. If they require hip reading, they are referred to the League for the Hard of Hearing, which has cooperated with us splendidly, or to the night classes for hip reading in one of our high schools

Our Center has the approval of the county Conservation of Hearing Committee, and some otologists and clinics are beginning to refer patients to us for assistance, in addition to many state rehabilitation cases from the Albany area. We are now known by most of the school physicians and nurses in the surrounding territory and treat patients from as far as a hundred miles away.

One of our big problems now is to find lip reading teachers in town and in the outlying districts Good ones are scarce, and an adequate number of good teachers are not being trained

We have been working with the State Education Department to start a course in the New York State College for Teachers on a graduate level, but there are many obstacles still to be overcome They all do not seem to realize fully the importance of such a project I would suggest that our state committee might take some action in this regard

MEDICO-SOCIAL STUDY PLANNED OF HUMAN REPRODUCTION

Both the medical and the social aspects of human reproduction will be the subject of a research project announced by Dr Haven Emerson, chairman of the National Committee on Maternal Health

The study will be under the direction of the National Research Council. Its main areas were outlined as follows

"(1) The physiology of and the factors con-

trolling conception, (2) the causes of sterility and treatment for infertility, (3) maternal and fetal physiology and clinical disorders developing during pregnancy, (4) the psychologic problems of marriage and the family relationships, (5) the population aspects of these problems, social and economic as well as medical."—Better Times, December 26, 1947

OTOSCLEROSIS ITS PATHOLOGY AND TREATMENT

Franz Altmann MD and DeGraaf Woodman MD, New York City

(From the Department of Otolaryngology Columbia University College of Physicians and Surgeons and the Presbyterian Hospital)

OTOSCLEROSIS is a disease of the essecus labyrathine capsule which in the majority of instances involves both sides, although not always symmetrically. It is characterised histologically by destruction of the capsular bone in certain areas followed by the formation of new bone.

Otosclerotic foci are found in 80 per cent of the cases near the anterosuperior circumference of the oral window. In 15 to 20 per cent of these cases the focus extends into the stapedial foot plate causing a loss of motility of the latter, a so-called stapedial ankylogis.

Inasmuch as normal motility of the stapes is essential for normal perception of air borne sounds, any restriction of this motility will result in a decrease in the acuity of hearing

The complete ankylosis of the stapedial foot plate is often preceded by the formation of fibrous adhesions between the oto-clerotic focus and the anterior crus of the stapes. Foci located in the region of the round window are next in frequency. These are usually found along the lateral part of the attachment of the round window membrane. Foci are less frequently found in other areas such as in the stapedial foot plate itself (primary location) or in the cochlear capsule. All these latter foci do not cause any impairment of hearing.

The lining membrane of the middle ear usually shows little or no change from normal. Oto-clarists, however, may also occur in ears showing evidence of a coexistent active or healed suppurative outline media.

Symptoms

Deafness starting insidiously and progressing showly is the main clinic symptom of otosclerosis in many instances it is accompanied by head noise, in some by dizziness. In the great majority of cases both ears are affected, often to a different extent. The progress of the hearing loss is, as a rule not continuous but interrupted by sta longity periods of varying length

Great differences of speed are shown in its progression. In some cases the hearing is still fairly good after many years, whereas in others a high degree of deafness develops within a relatively abort period of time. Retention of a cer

Provented at the 141st Annual Meeting of the Medical Socentr of the State of New York, Buffalo, Section on Ophthalmalogy and Otolaryngology May 9 1947 tain level of hearing for many years is no guarantee for its continued maintenance, it may be followed at any time by a sudden deterioration from the fact that stapedial ankylosis occurs in only 15 to 20 per cent of the cases with a focus in the neighborhood of the oval window, or in about 12 to 10 per cent of all the cases of otosclerosis the conclusion can be drawn that only about 15 per cent of all the cases of otosclerosis are accompanied by deafness and can be clinically diagnosed, whereas 85 per cent will remain undetected throughout life.

Frequency, Sex Predilection Heredity

The disease is more than twice as frequent in women than it is in men occurrence is often found. It seldom starts histogically before the age of five years, and the clinical symptoms rarely become manifest before puberty. In our opinion in none of the cases in which otosclerotic foci were described in embryos can this diagnosis be proved. Pregnancy particularly the second pregnancy, and menopause often have an unfavorable effect upon the condition.

Although there can be hardly any doubt about the importance of the hereditary factor, the exact mechanism of the transmission of the disease still remains obscure. This is understandable if one keeps in mind that otosclerosis becomes clinically manifest in only 15 per cent of the persons affectod with the disease. The remaining 85 per cent in which no stapedial ankylosis has developed may, however transmit the disease in exactly the same way as the 15 per cent with ankylosis. Freedom from clinic symptoms can by no means be taken as proof of freedom from histologic otosclerosis Reliable genetic studies will not be possible until histologic series of the temporal bones of all the members of affected families are available, and at this time such a study seems to lie in the remote future.

Routine histologic examinations of temporal bones have shown that otoselerotic foci are present in about 10 per cent of all the adult whites and that the disease is about 8 times more frequent in whites than among the negro population in the United States From these findings the conclusion can be drawn that about 12 million people in the United States harbor otoselerotic foci in the temporal bones and that more than 1 500 000 of them show hearing defects resulting from this disease.

Secondary Involvement of the Perception Mechanism

In the beginning stages of otosclerosis, the hearing loss is of the pure conductive type characterized by reduced hearing for air-conducted sounds but normal hearing for bone-conducted Later on, a progressive involvement of the perceptive mechanism is noticed Its time of onset and its extent show considerable individual variations In some cases it does not exceed the amount found in the population at large in similar In many others, however, it is much more The cause of this so-called nerve demarked generation is unknown Most probably, it is not caused by the otosclerotic lesion itself nor by direct involvement of parts of the neural apparatus, a rare occurrence, but is only secondary to the lesion and the sequel of certain still undetermined conditions brought about by the presence of the The term "involvement of the otosclerotic focus perceptive mechanism" seems preferable to the commonly used "secondary nerve degeneration," because it is not known which part of the neural apparatus is actually involved

The cause of otosclerosis is still unknown As far as we know at the present time, it is a disease confined to the temporal bones without any evidence of an underlying metabolic, endocrine, or

other disorder

Treatment

Considering the pathology of the disease, one can easily understand that local or general treatment is useless Catheterization of the eustachian tube might help to clear up accidental tubotympanal catarrhs which often cause a temporary increase in the loss of hearing Massage of the drum membranes might bring some improvement of very short duration in the relatively rare cases with fibrous adhesions between the focus and the anterior crus but without complete ankylosis seems unlikely, however, that such procedures could bring any relief in cases with complete ankylosis or that any medical treatment could achieve even an arrest of the disease or any improvement of the condition Thus, until recently, one could only make the diagnosis, advise against useless treatment, and suggest the use of a hearing aid and lip reading

The uselessness of the conservative treatment had already been realized by von Troltsch who was the first to advocate surgical therapy of the disease ¹ Since the presence of two functioning windows in the lateral wall of the labyrinth is regarded as essential for the normal transmission of air-borne sounds to the labyrinth, and since the oval window is occluded in otosclerosis, it is easily understandable that the first surgical

attempts were directed at mobilization or extraction of the stapes, the latter procedure in the hope that a connective tissue membrane would replace the removed foot plate. The results, however, were usually unsatisfactory. In many instances it was found technically impossible to remove the stapes. In others, in which the removal had been successful, secondary infection of the labyrinth or bony closure of the opening was the cause of failure. Therefore, the method was rejected by the leading otologists of that time

Others made labyrinthine fistulas into the promontory in the immediate neighborhood of the oval window, but also without permanent success Barany was the first to create the fistula in a semicircular canal 2 He chose the posterior vertical canal, Jenkins the lateral canal 3 Both investigators achieved only temporary improvements in hearing Holmgren, continuing these experiments, studied the problem for many years 4 He made fistulas in each of the 3 canals, sometimes in two of them simultaneously, and covered the fistulas with various kinds of tissues in order to prevent the closure His results were much better than those of the preceding authors but still far from satisfactory Sourdille worked out a technic with which for the first time fistulas were made into the lateral semicircular canal which remained open for more than five years 5 Sourdille's "tympanolabyrinthopexy" consisted, essentially, of making the fistula and covering it with a plastic skin flap continuous with the tympanic The procedure did not gain general acceptance, mainly because of the several stages, each separated from the other by months of convalescence

Lempert, using the principle of Sourdille's operation, improved it by making it a onestage operation which he named the fenestration operation 6 It consists, essentially, of removing part of the nonfunctioning ossicular chain, making a new labyrinthine window above the obstructed oval window, and connecting the drum membrane to this window by means of a plastic skin flap from the ear canal In the completed operation the vibrations of the drum membrane are now carried directly to the new window without the intervention of the ossicular chain the hearing with this reconstructed conducting mechanism is never entirely up to normal, extraordinary improvements and restoration of practical hearing have been achieved modified his method several times, the most important modification being the shifting of the position of the window from the lateral canal forward to what he calls the surgical dome of the vestibule ("nov-ovalis technic")7 This change in the position of the fistula reduced the tendency to secondary bony closure of the fistula considerably He also tried to achieve a further reduction by inserting a platinum indium frame or, lately, a small cartilaginous stopple, into the fistula, but these methods have found very few followers.

Animal experiments and the analysis of the histologic findings in human fistulas by Altimann have shown that infection and hemorrhages in the area of the fistula, trauma to the andosteum within the labyrinth, and bone chips left behind are the most important factors that promote bony cosure of the fistula. The enchondral layer of the capsule responds to trauma less rapidly with new bone formation than the periosteal layer Epithelium on the outer surface of the fistula particularly stratified squamous epithelium, exerts a retarding influence on bone formation

In accordance with most of the other authors we are using at the Columbia Presbyterian Medical Center the nov-ovalis technic without stopple and, as a rule, with the endaural approach have given up the complete exenteration of the pneumatic cells of the mastoid, because it makes the operative cavity unnecessarily large and thus prolongs the time required for the complete epithehalimtion of the cavity Secondary infection of the remaining cells has never occurred, possibly because of the prophylactic chemotherapy which is given for the first ten postoperative days (30 000 umts of penicillin intramuscularly every three hours) Particular care is taken to remove the periosteal bone in a wide area around the fistula, to remove carefully the bone chips to avoid trauma to the endosteum within the laby noth, and to thin out the tympanomental flap

As anesthesia, we have been using sodium pentothal. Ether should be avoided because it causes hyperemia and, in addition, makes the use of electrocautery impossible

Selection of Cases

Suitable for the operation are patients with good nerve function Since we are mainly interested in the patient's ability to understand speech, we pay particular attention to the so-called speech range between 512 and 2048 double vibrations. The hearing lose for bone conduction should not ex ceed 20-30 decibels because the bone conduction as a rule, remains unchanged even after a successful operation, and the hearing for air conduction can be expected to improve only up to the level of hear ing for bone conduction Since a hearing loss of up to 30 decibels for air conduction causes very little inconvenience at conversational distances, a hearing improvement up to and above this level would bring restoration of practical hearing Any improvement falling below this level would in many instances be unsatisfactory no matter how great the actual hearing gain in decibels

Age has nothing to do with the selection of a case for operation provided the patient is in good general health. However, in not many cases over fifty years of age and in very few over sixty years is the perceptive mechanism functioning well enough to make the operation worthwhile. If at that age the perceptive mechanism is still good we are evidently dealing with a bonign form of otosclerosts, and the question arises whether a hearing aid would not be more advantageous for the nation than the operation

Complications

The operation does not endanger the patient's life any more than any other major operative procedure. Postoperative infection has been kept down to a minimum by prophylactic chemotherapy for the first ten days after operation. The only more serious complications are facial paralysis, which is, as a rule, of a transient nature and perichondritis of the auricle which may lead to a deformity unless extensive through and through incisions for proper drainage are made in time.

Postoperative Course

After the operation the patients are dizzy for a few days but they are, as a rule able to be out of bed on the fifth postoperative day or even earlier and are discharged from the hospital on the tenth The dizzness usually disappears com pletely after a few days, but in some instances may persist for a few weeks or even months particularly on sudden turning movements of the head and when bending down. The epithelialisa tion of the operative cavity is in most instances completed within two to three months, particu larly if only an incomplete mastoidectomy has been performed Sometimes the epithelialization 15 delayed much longer by the formation of granu lations, and an annoying discharge may persist for some months

The hearing immediately after the opening of the labyrinth is considerably improved, but within one to three days after the operation it may drop down, sometimes even to a much lower level than that noted before the operation drop in hearing is caused by a labyrinthine irrita tion, a so-called serous labyrinthitis which usually subsides within ten to twenty-one days after its onset, after which the hearing returns rapidly to the previous high level. In certain cases, how over, the serous labyrintliitis causes more severe or often irreparable damage to the organ of Corts In that case the hearing improves at a much glower rate within two to six months or to a limited extent in the low tones only with the high frequencies remaining depressed. In some cases the hearing does not improve at all and may

remain even worse than it was before the operation In all such cases the results are unsatisfactory in spite of the presence of an open fistula

Among the factors responsible for the labyrinthitis is postoperative infection of the wound, which can be kept down to a minimum by sterile technic and prophylactic chemotherapy. But aside from that, blood and serum escaping from the undersurface of the tympanomeatal flap into the perilymphatic space may play an important role, causing an aseptic inflammation

The hearing improvement, apparent after the effects of the postoperative serous labyrinthitis have been overcome, is not always permanently maintained because of the tendency of the fistula to secondary bony closure This tendency is most acute during the first few months after the operation, later on, the osteogenesis becomes less About 85 per cent of the fistulas and less active that close do so within the first year after operation and only 15 per cent during the second year (Shambaugh) After that time all osteogenesis, as a rule, has ceased, and an open fistula with hearing improvement may be regarded as almost permanent The tinnitus often disappears after opening of the labyrinth and in many instances remains absent as long as the fistula stavs open very often returns when the fistula closes.

Evaluating End Results

It is difficult to get exact data about the permanent results of the operation Many of the figures given in the literature seem too optimistic This is mainly due to the fact that only a few of the available statistics report the average hearing results two or more years after the operation, and some report the average hearing gain for the conversational frequencies in decibels regardless of whether this improvement has brought about restoration of practical hearing or not We agree with Lempert that such a computation is misleading and does not permit a true evaluation of the results Instead, the cases should be divided into the following four groups

- Satisfactory rehabilitation for social and economic purposes, if the hearing was improved to the 30 decibels level or higher for the conversational frequencies 512, 1024, 2048 decibels, allowing only for the normal variable of 5 decibels of audiometric testing
- 2 Partial rehabilitation, if the hearing was improved but did not reach the practical 30 decibels level in all the conversational frequencies. Many of these patients, however, particularly those with marked improvement at 2048 double vibrations, are, subjectively, highly satisfied with the result of the operation.

- 3 No change in postoperative hearing
- 4 Postoperative deterioration of hearing

Even when one adopts a conservative attitude, one is justified in assuming that, in suitable cases, there is a 60 per cent chance, at least, for permanent restoration of practical hearing. This is confirmed by the results in cases which were operated upon by us at the Columbia Medical Center one year ago or longer.

In about 35 per cent there is a less spectacular, although sometimes still satisfactory, improvement, or no improvement at all. If this is due to a secondary bony closure of the fistula, a revision can be performed, and the newly formed bone removed. In many instances this will result in a permanent complete rehabilitation. If it is, however, due to the after-effects of a postoperative serous labyrinthitis, no correction is possible. In all such cases the patient is still able to wear a hearing aid on the operated ear.

In about 5 per cent of the cases the hearing gets worse or becomes entirely lost. These cases are regrettable, but one should keep in mind that the operation is generally done on the more affected ear and that very often otosclerosis leads eventually to a marked loss of hearing.

It is now believed by some authors that a successful operation stops not only the progressive loss of hearing for air-conducted sounds but also the secondary changes in the perceptive mechanism This is deduced from the observation that the hearing in the nonoperated ear continues to deteriorate while it remains unchanged for air conduction as well as for bone conduction in the operated ear Definite confirmation of this assumption would be of the utmost importance and would drastically change our present operative indications The fenestration would then become advisable in the great majority of all the cases of otosclerosis with a progressive hearing loss instead of just those with a practically intact perceptive mechanism In cases in which the operation would not restore practical hearing, it would at least prevent its further deterioration and would assure the patient of a permanent partial rehabilitation which, if necessary, could be further improved by the use of a hearing aid

Operation Versus Hearing Aid

A good hearing aid will give, in not too far advanced cases of otosclerosis, as much or even more sound amplification than a successful operation. However, it does not eliminate the noise, and there will always be some sound distortion which makes it a poor substitute for normal hearing. For that reason many patients who already wear an aid want to have the operation and are much more satisfied with a successful operation than they were with the hearing aid. The most

senous objection against the use of a hearing aid in operable cases is the fact that the aid fails to stop the progress of the disease. The more the disease advances, the less useful the hearing aid becomes but at this late stage the operation has already become impracticable, and the opportunity for permanent full rehabilitation has been lost. A hearing aid can be an important help in cases in which the operation has achieved only a partial rehabilitation

Pregnancy and Otosclerosis

Pregnancy often has an unfavorable effect upon the hearing in otosclerosis. For that reason many otologists advise women suffering from this disease not to have any children fenestration operation has changed our attitude toward this problem. If pregnancy occurs in womer who were not operated upon the hearing should be carefully watched If it deteriorates, the fenestration operation is performed by some surgeons even during the earlier part of pregnancy or shortly after its termination

Advising against pregnancies for eugenic rea sons appears of doubtful value Only 15 per cent of the persons afflicted with otosclerosis show reduced hearing, the other 85 per cent who have normal hearing remain undiagnosed and may nevertheless transmit the disease as mani fold cases do

Under these circumstances, there is no hope whatsoever of eradicating the disease by even the most drastic eugenic measures, but, fortu nately otosclorosis has lost much of its stigma through the possibility of successful surgical treatment of the disease

Summa-y

In spite of the remarkable progress which the ptosclerous research has made in the last fifty years, many problems remain unsolved most important of them is the cause which is still as puzzling as over Only after a complete clarification of its cause can we hope to find the means for prevention of or an actual cure for otosclerosis

Although the surgical treatment is only a pal liative procedure which does not climinate the disease its significance can hardly be overesti-Without undue evaggeration it might be said that the successful development of this opera tion is the greatest achievement in this special field of otology since the introduction of the calone vestibular tests by Barany about forty vears ago 10

The fenestration operation not only restores the hearing to a large group of patients but also lins greatly stimulated the interest of the otologasts in the problems of the physiology of hear ing in general It is to be hoped that through an intensified collaboration between clinicians and physiologists methods will also be found to improve the hearing in other types of deafness which up to the present day are still regarded as meurable

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AWARDS MADE FOR CANCER RESEARCH A million and a half dollars—the largest grant of Public Health Service funds ever to be given at one time was awarded recently to a total of 64 colkees, research laboratories and public health in

ritations throughout the country by the National Advisory Cancer Council of the National Cancer Cancer Council of the National Cancer Council Cancer teaching grants and cancer control grants recommended in the final sossions of the December meeting of the National Advisory Cancer Council, were given to the following institutions which are located in New York State

College of Physicians and Surgeons Columbia University New York \$23 976 Syracuse Uni-University New York \$23 976 Syracuso University Medical College Syracuse \$24,900 New York University College of Modicine New York, \$24,732 New York Medical College, Flower and Fifth Avenue New York, \$24,900 University of Rochester Rochester, \$25,000 University of Also Memorial Hospital Center for Cancer and Allied Diseases New York City \$5,000 and Memorial Hospital New York City \$25,000

THE TREATMENT OF INTRINSIC CANCER OF THE LARYNX

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(From the College of Physicians and Surgeons, Columbia University)

THE PRESENT discussion will deal only with intrinsic cancers of the larynx and their treatment. Ninety-five per cent of these cancers arise on one of the vocal cords.

The principles governing the treatment of cancer call for (1) the complete removal of the primary growth, and (2) the removal or destruction of all possible lymphatic involvement. In connection with early intrinsic cancer of the larynx, only the first of these requisites is applicable. Since the vocal cords are poorly supplied with lymphatics, wide removal of the primary growth is sufficient to effect a cure. The lymphatic fields, unless these are palpable nodes, need not be regarded.

Two methods of treatment are at the disposal of the surgeon, radiotherapy by means of radium or x-rays, and surgery

Radiotherapy

The use of radiotherapy in cancer of the larynx is based on the power of radium and x-rays to destroy the living cells. Cells near mitosis and tissues in which the cells are dividing frequently are believed to be especially sensitive to irradiation. Most cancer cells are of this type and as such are more readily destroyed than normal cells. If their resistance to radiotherapy approaches or equals that of the surrounding normal cells, the cancer may not be destroyed without destroying the surrounding cells. Consequently, no radioresistant cancer, situated in a vital area, can be justifiably treated by radiotherapy

Radiosensitivity and radiocurability are not always synonymous. A superficial cancer, even though not very radiosensitive, can be cured, because a sufficient dose can be delivered to it without harming the surrounding tissue. On the other hand, a radiosensitive tumor, if infiltrating, may not be curable by irradiation, because of the impossibility of delivering a lethal dose to the cancer cells without harming the circulation and lymphatic drainage to such a degree as to leave the organ an easy mark for infection and necrosis

Irradiation by radium or x-rays has hitherto only been condemned by laryngologists. The line of reasoning was as follows since 96 per cent of laryngeal carcinomas are of a rather well differentiated squamous cell type, they are not, as a rule, radiosensitive. In incipient or doubtful

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Oph thalmology and Otolary ngology May 9, 1947 cases, the reaction to radium treatment may obscure the clinical picture, making it impossible to estimate the extent of the disease or to complete the diagnosis. In reply to this, it may be said that no treatment should be started until the diagnosis is complete. Radium or x-rays may produce marked recession of the disease, even to the point of apparent disappearance. On reappearance, the same reaction to radiotherapy may again be brought about but to a less marked degree, and so on until the growth is completely radioresistant. Surgery cannot then be used, for the wound will not heal

These objections no longer hold true to this degree. In recent years rapid improvement in the technic of \(\tau-\text{ray}\) therapy has been made, so that apparently many of the former difficulties have been overcome. When radiotherapy is successful, the result is a larynx, intact and without deformity. No surgery can produce such a result. In view of such perfection in results, the claims of radiotherapy cannot be lightly dismissed, and surgeons should cooperate, wherever possible, to ascertain the indications and limitations of its use

Radiotherapy has an additional advantage in border-line and extrinsic cancers in which the lymphatics are probably or definitely involved. The fields of radiation may be so arranged that not only is the primary growth treated, but the lymphatic drainage is covered at the same time

Radiotherapy in the United States is largely confined to the use of x-rays. The claim is made that x-rays will do all that radium will do and is more convenient to apply. X-rays are more generally applicable. In special cases, however, such as recurrences in the lymph nodes, radium needles may be used. The decision in these cases should be left to the radiotherapist, since the laryngeal surgeon, unless working in a cancer hospital, will not be sufficiently familiar with the details of radiotherapy either to select cases or to carry out the meticulous treatment.

X-ray therapy is readily accessible, and, when correctly given, is just as successful as application of radium. The technic or x-ray therapy is constantly being improved, and it is possible that in the future it may replace surgery. The favorable cases are those in which the growths are superficial, have a tendency to sprout into the larynx, and involve no vital tissues. These are also cases in which surgical treatment is most favored.

The choice between radiotherapy and surgical treatment of caronioma of the larynx will at times be difficult. The medical profession and oven the latty are so much on the lookout for early cancer of the larynx that extremely early cases are now seen quite frequently, whereas in former years they were seen only rarely. Early superficial cases undoubtedly have been cured by radiotherapy and, considering the perfection of the result one is strongly tempted to adopt this procedure in these early cases.

The most recent statistics are decidedly favor able. Lens at the Presbyternan Hospital reports 8 five-year cures out of 10 cases of vocal cord tumors treated ¹. This record is about the same as that obtained by laryngofissural removal. In all he has treated 40 cases of vocal cord carcinomas and 110 cases of all types, and has attained 30 five-year cures the most successful of which have been those of the vocal cords. Pyriform tumors on the other hand, give the poorest results

Cutler of Chicago recently reported a series of 118 unselected cases with a five-year cure rate of 42 per cent. His results in early cases treated with radiotherapy were equally as good as those in laryngofissural removal

Surgical Treatment

These early growths may be removed by intra laryngeal dissection or by laryngofissure

Preparation for Operation —All surgical operations on the larynx should be preceded by the most careful proparation of the patient. This preparation includes hospitalization of the patient for several days or a week, careful exammation of the pulmonary, circulatory and urmary systems, blood chemistry analysis with removal, if possible of abnormal constituents from the blood stream. The mouth and teeth also should receive the most careful attention

All surgeons try to follow certain principles in order to avoid complications, the most dangerous of which are postoperative hemorrhage and post-operative pneumona. Surgeons vary their technic to a considerable extent but all carry out most careful hemostasis and protect the lungs from aspiration of blood

Every patient before operation should receive about 100 000 units of penicillin daily in divided does for several days. This will greatly diminish postoperative complications and allow primary bealing within a week in a large number of cases

Anethesia — Preliminary medication should be bed with caution, as morphine or other sedatives interfere with the cough reflex, which is such a powerful protection to the lungs

Blocking of the cervical plexus is used extensively in Europe In fact, Hamberger and Diamant state that most operators use that method. A number of major operations on the larynx have been performed at the Presbyterian Hospital, New York City using this method the injection of novocain and adrenalin along the border of the sternomastoid muscle on either side then in the midline along the course of the incision. This has been very satisfactory. There are dangers attached to the procedure, however and only a skilled anesthetist should employ it

The majority of American surgeons prefer general anesthesia, contending that only with this anesthesia is it possible to secure the quiet surgical field necessary for careful and accurate work. English surgeons prefer chloroform for its quicker effect and less irritating quality. Others prefer ether, given either by inhalation or by rectum Avertin by rectum or sodium pentothal intravenously have been used as foundation anesthesia, re-enforced by either local or general anesthesia by inhalation. The same objection may be raised against rectal anesthesia as against preliminary medication by morphine, i.e., the patients do not recover the cough reflex promptly Nevertheless whatever anesthesia is used, it will be safe only in the hands of an expert anesthetist

Operations -- (1) General anesthesia must be This limited used for intralaryngeal removal procedure is justified on the grounds that an early cancer involves only the epithelial layer of the mucous membrane and extends along the cord without infiltration The method should be used to remove only very small growths limited to the middle of the cord and not affecting its mobility In two instances, formerly reported, the present author has had the expenence of completely removing small growths at biopsy 4 In one of these cases, although the tissue removed was evidently cancerous, the cord healed smoothly, and there was no recurrence of the growth. In the second case sections of the cord removed after a posi tave biopsy, showed no malignancy. A third case, more recently seen repeated the experience of the first.

Lynch originated this operation and reported 9 cases, of which only 3 had had recurrences at the time of his report. This is a larger percentage of recurrences than should occur after a well performed condectomy. LeJeune, who has continued the work of Lynch, reports a larger series of cases with better results.

The larynx is exposed with the suspension apparatus. Then, the growth is cut about and removed, the incision being well away from the edges. The raw surface may be lightly touched with a coagulating electrode. The results in the successful cases as to function can be compared to those attained by radiotherapy. Careful observation will detect any recurrence at which

time a more radical operation may be performed, since the cartilaginous box which confines the neoplasm has not been injured

A great deal depends on the degree of malignancy Those graded #1 need only close removal, those of greater malignancy must be removed more extensively

(2) A laryngofissure is merely an incision into The more proper term would be the larynx partial laryngectomy by the laryngofissural route Laryngofissural removal gives its best results with early intrinsic laryngeal cancers, limited to the central area of one cord and not yet affecting the mobility of the cord Decrease of mobility of the cord signifies that there has been penetration of the cord itself and the muscles controlling its movement Fixation of the cord means that the arytenoid region has been reached by the growth When this occurs and especially when the anterior end of the opposite cord has been involved, the cancer is advanced

The significance of limitation of mobility is illustrated by Dr St Clair Thomson In 37 cases where the cord was mobile, 84 per cent three-year cures were obtained, in 20 cases where the movement of the cord was impaired, 75 per cent three-year cures were obtained, and in 9 cases, the cord was fixed, and only 44 per cent cures were obtained

When the aryepiglottic fold, epiglottis, or subcordal region have been invaded, the case is less suitable for attack by the laryngofissural incision. The two reasons for this are the great probability that the thyroid membrane or the cricothyroid membrane has been penetrated and the subcutaneous tissue invaded, or the probability that the region of lymphatics has been reached and lymphatic invasion may have occurred

There is now a tendency among laryngeal surgeons to extend the indication for the laryngofissural operation Even when the cord is fixed or the subglottic region or the anterior commissure invaded, it may be possible to surround the growth and remove it entirely Only evident invasion of the ventricular band, the subglottic space, or the arytenoid region contraindicates such an operation Moreover, the operation may be followed by radiotherapy which will increase the chances of cure Of course, the more extensive the removal of tissue, the poorer the voice will be Yet, all patients prefer even a whisper to the esophageal voice or to no voice at all It must always be remembered that the more the indications are stretched, the greater the danger of recurrence and the fewer the chances of a later successful laryngectomy

The incision is made from the hyoid bone to the substernal notch and deepened through the soft tissue to the thyroid cartilages and trachea
It is

probably safer to divide the thyroid isthmus Care should be taken not to strip back the perichondrium from the thyroid cartilage. The interior of the trachea and larynx are anesthetized by injecting a few drops of 10 per cent cocaine solution between the tracheal rings and through the cricoid membrane The trachectomy tube is now inserted into the trachea well below the cricoid cartilage, if possible, through the third and fourth rings The next step is the splitting of the thyroid cartilage In the ordinary early case in which the growth is limited to one side of the larynx, this can be done in the midline by making an incision through the cricothyroid membrane, inserting a blunt-pointed, angled scissors up through the larynx, and dividing the cartilage and soft parts of the interior of the larynx with one The wings of the thyroid cartilage are then retracted and the growth exposed, care being taken not to lacerate or bruise the edges of the cartilages At this stage, protection of the lungs from bleeding is most important. This is done by packing the trachea above the tracheotomy tube with gauze, and by prompt removal of all blood and secretion through a suction tube in the hands of an assistant Excision of the growth is next completed The soft parts of the side of the larynx which presents the growth are stripped from the cartilage, care being taken to raise the inner perichondrium. This is done without difficulty except below over the cricothyroid membrane and above the edge of the thyroid car-However, since this procedure is not adapted for the removal of growths which invade the regions above and below the thyroid cartilage, no stripping there will be required

Excision of the growth is carried out so as to leave a surrounding free margin of tissue by making a straight vertical incision with scissors toward the arytenoid region above and below the growth, taking in, of course, the whole thickness of the tissue

These incisions are carried backward as far as is necessary to extend beyond the growth, at times to the arytenoid, then, the mass of tissue separated above and below is cut away with rightangled seissors by an incision running in the long axis of the body Hemorrhage must be carefully controlled One or two vigorous spurters will probably be found at the upper and lower margins of the excised area These should be seized with artery forceps and tied, either with ordinary ligature or a suture ligature It has been found that a special broad-bill forceps facilitates the tying of these deeply-placed arteries A bronchoscope is passed into the trachea and all blood The larynx is closed by carefully removed suturing the external perichondrium of the operated side to that of the unaffected side The

raw surfaces are powdered with sodium sulfadianne and the soft parts are closed in layers with out drainage

Postoperative Care

The patient is returned to bed and placed in a semirechning or sutting position section is carried out by passing a small catheter through the tracheotomy tube. Only in cases of extreme necessity may a bronchoscope be used The tracheotomy tube is left in place from twelve to twenty-four hours, since there will be a good deal of secretion from the trachea, and some blood, in spite of all care, may have escaped down ward. In a few hours, an attempt is made to give the patient sterile water by mouth. After a few trais he will probably be able to swallow without any of the water coming through the tracheotomy wound The patient is kept on sterile water for twenty-four hours, when a regular fluid diet may be given with solids gradually being added If all goes well, the patient should be out of bed in twenty four or forty-eight hours Should the feeding by mouth be found impracticable, a naml catheter may be inserted and kept in place as long as may be necessary Thus will rarely be required.

During the week immediately following operation penicilin should be continued. This will greatly diminish the danger of complications and promote healing.

The subsequent care of the patient consists, chefly, of the removal of the granulation tissue which forms in the larynx, and which can be kept under control by application of silver intrate through the direct laryngoscope or excision with laryngeal forceps. Healing will take place in two or three months. The voice after several months may return almost to normal, although in most matances some hourseness will perust. The vocal result depends on the remaining mobility of the arytenod. If this is preserved, a new vocal cord will form. Although large parts of both vocal cords may be removed a good voice will be the result, if both arytenoids move freely

Occasionally, the granulomas which form at the site of the excised cord may cause great anxiety as to whether or not they may be early returrences. They should be kept under careful observation. If benign, they will show a tendency to regress after a short time. If, however, the tendency is to grow, they should be removed and sectioned. If found to be malignant a prompt laryngectomy must be performed. If the edges of cartilage have been injured, the wound may require a long time to heal, with a fistula persuing externally, and excessive granulations forming internally. Usually, a small sequestrum

forms under the incision. Once it has been removed, the wound will heal promptly

The above-described operation is one which may be used in early cordal growths of small size Should the growth be more extensive calling for removal of considerable tissue in the arytenoid region or part of the opposite cord, variation in the technic must be used. The cartilage may be opened by a hand saw or an electric saw, carrying the incision down to the inner perichondrium taking the greatest care not to penetrate the interior of the larynx As many of the soft parts of the larvax are then strapped off the cartilage as may be necessary to get beyond the growth, wherever it is The interior of the laryn's is then opened through normal tissue taking care always not to cut through cancerous tissue as this greatly increases the chances of recurrence By this method of incusion of the cartilage and the supporting inner penchondrum, portions of both cords may be removed successfully as far back as the arytenoids. Some surgeons prefer to excise the growth by using the diathermy knife. Some, even though they do not use the diathermy knife. congulate the edges after the growth has been removed by sharp dissection

Certain surgeons do not use a tracheotomy tube as a routine measure but dispense with it whenever they feel it can be done with safety. It is probably better to use a tracheotomy tube in every case, since this makes it possible to control postoperative hemorrhage more easily by reopening the laryax and packing it.

Dr St Clair Thomson, who has been most successful in operating on intrinsic cancers of the larynx through the laryngofissural incision, ad vocates the removal of the thyroid wing on the To effect this the external diseased side perichondrium as well as the inner perichondrium is stripped back, and the cartilage, all except its posterior border is excised with the right-angled scissors. It is maintained that the interior of the larynx heals more quickly with the formation of less granulation tissue when this procedure is adopted Removing the cartilage is objected to on the grounds that the retained cartilage is a barrier to spread in case there is a recurrence On the other hand, successful secondary larynged tomies have been performed even when the car tilage has been proviously removed

In the case of anterior commissure growths, portions of both thyroid cartilages may be removed together with underlying tissue even to the extent of leaving scarcely any little laryngeal lumen. In such cases a permanent tracheal fistula must be retained but a whispering voice will be preserved.

The objection to these extensive partial re-

sections is that in the case of growths so large as to call for such procedures, very likely there will already have been invasion of the lymphatics or parts external to the larynx. It may be said that justice is not done to the patient in such cases, unless total laryngectomy is employed.

Use may be made of a laryngofissure as an avenue of approach for the insertion of radon seeds. In the case of growths too large to be removed, the laryngofissure, nevertheless, gives excellent visibility, and radon seeds may be placed accurately. Their number and strength are graded according to the size of the growth Some cures have been reported.

Advanced intrinsic cases with fixation of cord. invasion of one or other of the commissures, the ventricular band, or subglottic space should be treated by total laryngectomy Until recently one would have said that such cases should all be submitted to laryngectomy Radiotherapy. however, is undergoing rapid improvement Authors have reported cures approaching 50 per cent of cases which certainly matches the cures by If this improvement in x-ray therapy continues, the limitations of surgery will be narrowed For the present, however, laryngectomy should be chosen for the advanced cases, especially for the following reasons since the danger of radionecrosis has not yet been overcome, even where the cancer is completely cured, the condition of the patient may be so miserable that a laryngectomy must be performed to stop pain and sepsis, and when there is recurrence after radiotherapy, and a laryngectomy is performed, healing is hard to obtain, although not The author has seen several such impossible cases which healed after radiotherapy at the Presbyteman Hospital Any radiotherapy, however, complicates surgery

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Discussion

Maurice Lenz, MD, New York City—For the past seventeen years Doctor Kernan and I have had a joint monthly follow-up clinic for patients with cancer of the larynx treated either by surgery or x-ray. Those receiving roentgenotherapy between 1931 and 1941 were reviewed in May, 1946, and reported in the Journal of the American Medical Association, May 10, 1947. Of the 128 patients treated only by x-ray, 30 were free from clinical evidence of cancer five to fourteen years after the treatment. The main factors determining the result were extent and location of the cancer and, es-

pecially, invasion of the arytenoid cartilages and lymph nodes. Thus, the disease was chincally arrested for five to fourteen years in 17 of 40 primary cord cancers, and in 9 of 28 cancers of the epiglottis, while the treatment failed in all of the 26 cancers of the piriform sinus.

Among cordal cancers the extent of the cancer had a definite influence upon the result. Thus, all the 6 cancers limited to the anterior or middle of one cord got well. This also occurred in 4 of 6 cordal cancers with extension either to the anterior commissure or the opposite cord or band, and in 2 of 3 patients with cordal cancer partially fixing the arytenoids. Among 21, however, in which the arytenoid was completely fixed, only 4 were arrested, 9 of the remaining had clinically metastatic lymph nodes, and they all died

Among the 9 primary epiglottic cancers free from chinical evidence of the disease from five to fourteen years, 8 had clinically metastatic cervical lymph nodes and 11 fixed the arytenoids either completely or partially Chondronecrosis occurred in most cases of epitheliomas invading the epiglottis, including those which healed. It was also frequent in those epitheliomas invading the arytenoids, but here this complication was much more serious and partially accounted for the low cure rate.

It is our belief that roentgenotherapy in early cancer of the cords gives as high a cure rate and a better voice than laryngofissure

In cordal cancer completely fixing the arytenoids, and in subglottic involvement, laryngetcomy is more reliable. We do not object to a preliminary trial with roentgenotherapy if the patient understands that he may have to have a laryngectomy later should roentgenotherapy fail. Healing after laryngectomy in these previously irradiated cases is not delayed and may be done without the fear of necrosis, if the roentgenotherapy has been carried out slowly and carefully

A mere statement of roentgen dosage does not describe the care and accuracy used in the treatment. There is as much difference in roentgenotherapy in various clinics as in surgery. Only a continued, joint follow-up clinic can teach the person treating cancer of the laryny whether surgery or radiotherapy is preferable in a given case. The choice of treatment of a cancer of the laryny should be made jointly by a laryngologist and a radiotherapist, as either or both of these forms of treatment may be applicable to a particular case.

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A STUDY OF SURGICAL MASTOIDITIS OCCURRING IN CHILDREN AT THE BUFFALO CHILDREN'S HOSPITAL DURING THE YEARS 1945 AND 1946

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THREE YEARS ago Dr Walter Dean read a paper before the Southern Medical Association, entitled "Otitis Media Still Takes Its Toll" He declared that the object of his paper was to "amplify and atress an important field which is badly managed in practice" In this paper he reported that 3 5 per cent of all rejections in the draft were due to defects of the middle car He quoted statistics to show that in 1940 in this country there was one "ear" death in every 337 deaths This compared unfavorably to Paulson's figures of one death in every 303 in Copenhagen over 40 years ago

Surely, if one considers the morbidity and mortality arising from acute suppurative of its media and the hundreds of thousands of people suffering from impaired hearing due to this condition, then we must conclude that this is a very important and dangerous disease with many undesirable potentiallities.

The proper management of acute otitls media has been fairly well agreed upon among otologists. It may be presumed that the following points have become almost noncontroversual

1 It is necessary to carry out prompt diagnoss and observation by one trained to observe and intrepret the changes that occur in the membrana tympani during acute infection.

Early myringotomy should be performed when fluid is present in the middle car

3 Active treatment with chemotherapy and antibotics should be carried out when the disease us till a nucous membrane infection. Such treat ment should extend over a period of approximately seven days in most cases and no longer than fourteen days, if the infection has not responded.

4. Chemotherapy and antibiotics should not be used to 'cure' bone involvement in an attempt

to avert operation.

It is readily conceded that no matter how earn extly and skillfully the treatment may be rendered, a certain nonreducible minimum of complications will occur. In order to ascertain whether this irreducible minimum has been reached a study was made of 105 consecutive mastodectomics occurring during the years 1045 and 1946 in the Buffalo Children's Hospital. These two years were chosen because medical practice in

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this community had about returned to normal with the release of the many doctors from the armed services Thus, if any lack of proper and intensive treatment were shown in the care of these cases during the early stages of the infection. it could not be laid to the fact that war had ren dered inadequate the usual medical facilities The incidence of mastoiditis in the Buffalo Children's Hospital for the past few years has increased little although the number of admissions has increased markedly the incidence of mastoiditis being 1 to each 107 patients in the two years this series was studied, 1 to 108 admissions in the previous two years and I case to every 130 hospital admissions in 1940 and 1941 During the venrs 1945 and 1946 there had been no unusually severe enidemics of acute infections to make this series different from an average series.

The following tables give some statistics which show that the group studied corresponds to the average group seen in any large city hospital for children. It should be noted that a majority of the cases occurred in the first nine years of life, which is the usual incidence.

TABLE 1 .- Age Incidence

Age	Number of Cases
1- 3 years	22
4 6 years	25
7- 0 years	37
10-12 years	17
18-15 years	10
16-18 years	4

Table 2 shows the incidence of the pathologic organisms and this also is in accordance with the usual statistics. All outlures were taken from the mastoid cavity at the time of operation. The unsatisfactory cultures probably resulted from either the use of chemotherapy in some of these cases or to an error in technic.

TABLE 2.-ORGANISMS

Hemolytic streptococcus	62 per cent
Pagamococcus .	9 per cent
Rtanhylogocous aureus or miso.	13 per cent
Staphylococous aureus or misc. Unsatisfactory cultures	12 per cent

Table 3 shows the time elapsed from the initial symptoms of otitis media to the operation and is interesting in that 18 cases were operated on within the first week. This might seem rather high but all 18 were well advanced cases of surgical mastoidits due either to the parents of the children not being aware of the onset of acute

otitis media at the time, or to the masking of early symptoms by chemotherapy given sometimes for a preceding upper respiratory infection. The above remarks apply also to the 21 cases operated on during the second week of the disease

TABLE 3 - DURATION OF SYMPTOMS BEFORE OPERATION

Length of Time	Number of Cases
1st week	18
2nd week	
3rd week	$\begin{smallmatrix}21\\25\end{smallmatrix}$
4th week	
5th week and above	12 18*

^{*} Of which 9 were for acute exacerbation of chronic outs media and mastoiditis.

We have attempted to plot accurately the medical treatment of the acute otitis media before the case came to operation The records have been fairly accurate and indicate that only 43 per cent of the cases had any chemotherapy and of these, approximately 40 per cent had what might be called madequate therapy Only 5 per cent of the total number were given penicillin and of these patients only one received it for more than three days Four per cent of the cases received combined sulfadiazine and penicillin doses, and in only one of these 4 cases was the dosage adjusted properly The other 3 dosages were entirely inadequate, consisting of a few tablets of sulfadiazine from time to time and a day or two on oral penicilin

Table 4 indicates the time elapsed from the beginning of the disease to the time aural discharge was first noticed. This, too, is very interesting, because 26 of the 73 cases that had spontaneous discharge ruptured after the third day, 5 of the total number of cases required myringotomy, and 13 had spontaneous perforation of the drum after the seventh day. This in itself would seem to indicate either a considerable degree of indifference to the course of the disease or a lack of observation by the attending doctor.

TABLE 4 -Time of Beginning of Aural Discharge*

Day of Disease	Number of Cases	Remarks
Ist day 2nd day 3rd day 4th day 5th day 6th day 7th day	23 12 12 7 2 4 13	1 required later myringotomy

 $_{\rm ^{9}Up}$ to the time of operation, 10 cases had had no aural discharge

Table 5 shows the surgical management of the cases of acute otitis media which preceded the surgical mastoiditis and which the children had before entering the hospital. It is interesting to note that of the 18 cases, 12 myringotomies were performed seven days or later in the disease, and that only 3 were performed before the fourth

day This, coupled with the fact that ten cases shown above had had no aural discharge at any time so far as could be determined at the time of operation, would indicate that there was a very definite lack of awareness of the fact that the middle ear should be drained when it contains pus

TABLE 5 —DAY OF DISEASE THAT MYRINGOTOMIES WERE

	FERFORMED			
Day of Disease	Number of Cases	Remarks		
1st day 2nd day 3rd day 4th day 5th day 6th day	1 2 0 1 0 2	5 included in Table 4		
7th day	12	5 cases had spontaneous dis- charge which stopped		

It is to be remembered that all these cases were sent into the hospital with a diagnosis of surgical mastorditis and were operated on shortly after being admitted Of the 94 cases of acute surgical mastorditis operated on, 6 presented signs of early or threatened intracranial complications consisting of 1 case each of meningismus, meningitis, epidural abscess, Gradenigo's syndrome, cerebellar abscess, cerebellar abscess and pensinuous infection There were 2 deaths in this series, one, a two-year-old child with an aleukemic leukemia with broken-down, infected mastoid cells The second death occurred in a boy of seven who developed a cerebellar abscess Myringotomy had been performed on the seventh day after the onset of symptoms of acute otitis media He had had no chemotherapy, having been treated outside the hospital for sinusitis with penicillin nose drops

It would seem from the above figures that nearly half the cases that came to operation for surgical mastoiditis had not had what would be considered adequate treatment by the majority of the otologists. If we ask ourselves why an adequate course of treatment was not carried out, the following points may present themselves as possible reasons.

- 1 Acute otitis media is so very common in children that it is generally considered a very minor complaint and one that will take care of itself in a vast majority of cases. Thus, in many cases, aside from prescribing ear drops or aspirin, no other care is given until more serious symptoms develop.
- 2 Paracentesis is not performed promptly enough Too many cases receive no treatment until the aural discharge occurs spontaneously, as was shown in the above figures. Too often, paracentesis is considered as a nuisance more or less, since the child must either be given an anesthetic or forcibly restrained, with the result that the true criteria for performing paracentesis are not considered.

3 The disease itself does not seem to be considered sufficient cause for prescribing chemotherapy, and, if therapy is prescribed, it is rarely carried out long enough. This was demonstrated in the above figures.

4 Lack of frequent careful observation by a tramed otologist. If the case was under his observation, it seems difficult to believe that any otologist would permit over 10 per cent of his cases to come to operation without any history of aural discharge. It is, of course, true that a certain number of cases will give minimal symptoms which have been ignored, probably, without calling a doctor. Also, as proviously mentioned, the symptoms may be masked in those cases which received chemotherapy for upper respiratory infections.

The question now arises as to just what may be done to remedy this situation. Inasmuch as a vast majority of all acute otitis media cases are not treated by the otologist, it seems that the only thing to do is to foster an appreciation of the scriousness of the complications that may arise from this disease among the practicing physicians The only way to arouse interest in this matter is to teach medical men the facts before they go into active practice To accomplish this, more stress and interest might be given to this subject in teaching our medical students. As a rule this can be most easily accomplished during the teaching hours in a pediatric hospital, where the disease is commonly seen in the outpatient departments. It has occurred to us that very probably we otologists have not taken as active a hand as we should in teaching these students in the outpa tient departments and in the wards

It also seems desirable that we stress the importance of proper care in these cases to the interns, all of whom will be in active practice within a short time. If we can awaken the interns to the fact that they undoubtedly, will see many such cases and will be mostly responsible for preventing surgical mastoiditis, then perhaps they will have a keener interest in and appreciation of the cases when such cases are encountered in private practice. It seems that such efforts over a period of a few years, along with the adequate therapeutic methods that we now have could decrease the incidence of surgical mastoiditis appreciably

468 Delaware Avenue

Discussion

Stnart L. Craig, M.D., New York City—Dr Bozer's well-presented and thoughtful study of 105 topes of surgecal mastoidits in children in a period of two years should give the otologist and the practitumer something to consider and act upon Dr Dean's paper which Dr Bozer quotes, is very revealing statistically in that it shows that mastoiditis and its sequelae have by no means been written off as causes of desability and death an idea generally necepted since the advant of more modern and advanced methods of treatment.

In the practice of otology in the large cities, among a class able to command the services of very com petent pediatrists or practitioners the incident of mastolidits has been markedly diminished and its complications reduced to a minimum. But among the less affluent classes where medical service is not sought or is casual the incidence is still high. In addition the fact that operative mastoids in private practice are comparatively rare while there is a relatively high percentage in the clinics shows the importance of early competent care.

There are several points in Dr Bozer's paper which I would like to underline Because chemotherapy and penicillin have proved so effective in controlling middle ear infection dependence is placed on the drug, and myringotomy or paracentesis have not been performed even in cases where there is frank bulging in the membrana tympani and fluid in the middle ear A paracentesis in my opinion is wase when there is definite evidence of fluid in the middle ear probably due to infection, and it lessens the chances of complications setting in and impair ment in hearing. Again where chemotherapy or penicillin is used, it should be given in sufficient amount to establish quickly and maintain a high blood level until the infection is under complete control Inadequate or sporadic doses of either of these drugs is confusing and dangerous. Again that the use of chemotherapy and penicillin should be instituted at the very beginning of the infection, when the invasion is confined to the mucosa, cannot be too strongly emphasized, since, in my experience they have proved to be ineffective after the mastoid cells contain frank pus We have found in practice that the use of sulfadiazine and sulfathiazole together increase the solubility and effectiveness of both and when the infection is resistant the use of penicillin and sulfa aimultaneously is advisable. All cases of chronic otitis media purulent should be under the care of a competent otologist. The majority if the infection is persistent should be operated upon. All cases of cholestentoms involving the masteid should be operated upon

Dr Bozer's recommendation of more training in otology for the practitioner and the intern is in my opinion, of the greatest importance and would solve the problem of those cases of otitis which are not diagnosed or are improperly treated in the early stages and would prevent those cases which are not referred to the otologist until ready for admission to the hospital for operation

With every student graduating from medical school having a reasonable training in a children eline or an ear clinic in totology with every graduating student fully equipped to evaluate the changes in the middle ear resulting from bacterial invasion with our present ability to control infection by the prompt and efficient administration of the sulfa drugs and peniellin, mastodists and its complications would become a steadily diminishing menace

Gordon D Hoople, M D Syracuse. Only one of

this series of cases which required mastoidectomy had an early myringotomy, (1 case within twenty-four hours of the onset of symptoms) Only about 20 per cent of the entire series had myringotomy. The remaining ears either ruptured spontaneously or had no middle ear discharge up to the time of operation. A majority of the 20 per cent had their myringotomy seven or more days after the onset of symptoms. These figures are most significant.

A number of years ago I studied the possible relationship between early myringotomy and haphazard surgical attention to drainage of infections of the middle ear in communicable diseases among the children of Syracuse I found that approximately 50 per cent of Syracuse's communicable disease patients are hospitalized. Having charge of the otolaryngologic service in the City Hospital, I insisted that all sudden fevers or pains in the ear occurring in these patients be investigated at once, even if they occurred in the middle of the night Myringotomy was to be performed at once if the indications were present. Thus, all hospitalized communicable disease patients were under otolaryngologics.

gologic control The remaining unhospitalized 50 per cent were not

The study was carried on over a ten-year period It was found that of the ears which developed suppuration after admission to the hospital, only 21 per cent went on to mastoidectomy. In contrast to this, it was necessary to do a mastoidectomy on 79 per cent of the ear cases which developed before admission to the hospital. (The majority of these were admitted to the hospital because they had ear infection and not because they had a communicable disease, and they can thus be grouped with the unhospitalized 50 per cent who had haphazard middle ear observation and care.)

I believe that if early myringotomy had been performed in each patient in Doctor Bozer's series a great majority of them could have been spared a mastoidectomy

Reference

1 Dean Walter South M J 37 2427 (Sept.) 1944

FIRST INTERNATIONAL POLIOMYELITIS CONFERENCE TO BE HELD IN JULY

Official delegates from more than 60 foreign governments will be invited to participate in the First International Poliomyelitis Conference at the Waldorf-Astoria Hotel in New York City next July 12 to 17, the National Foundation for Infantile Paralysis, sponsor of the conference, has announced

The foreign delegates will be asked to present summarizations of the problems of poliomyelitis in their countries at a special session presided over by Thomas Parran, M.D., Washington, D.C., Surgeon General of the United States Public Health Service

Official host to the delegates will be Basil O'Connor, New York, president of the national foundation Hart E Van Riper, M D, Washington, D C, the foundation's medical director, has been appointed general chairman of the conference

The program is being arranged by a sevenmember advisory board which includes Irvin Abell, M.D., Louisville, clinical professor of surgery at the University of Louisville, Morris Fishbein, M.D., Chicago, editor of the Journal of the American Medical Association, David Lloyd, Ph D, New York, associate member of the Rockefeller Institute for Medical Research, Kenneth Maxey, M D, Baltimore, professor of epidemiology at Johns Hopkins University, Frank Ober, M.D, Boston, professor emeritus of orthopedic surgery at Harvard University, and Thomas Rivers, M D, New York, director of the Hospital of the Rockefeller Institute for Medical Research

In addition to reports on poliomyelitis research and treatment by professional authorities and panel discussions on the various subjects, there will be a scientific exhibit section, demonstrations of muscle testing and treatment procedures, and a film program

Coordinating this phase of the conference will be an advisory committee of Thomas G Hull, Ph.D, Chicago, director of scientific exhibits of the American Medical Association, and Charles F Branch, M D, Boston, director of scientific exhibits of the American College of Surgeons—A M A News, December 19, 1947

ANTEROSEPTAL INFARCTION

MAURICE A DONOVAN, M.D., F.A.C.P., Schenectady, New York

(From the Department of Cardiology Ellis Hospital)

THE use of precordial leads as an adjuvant toward a more clear understanding of certain eardisc problems is generally accepted now by most cardiologists. Wilson and his associates proncered the use of these leads in 1930 12 In that same year while discussing a paper by Dr E. P. Carter before the Association of American Physicians, Wilson stated, "By taking precordial leads, as well as the usual three leads much ad ditional information concerning the spread of the excitation process over the heart and also we beheve, regarding the final deflection of the electroeardiogram, may be obtained. It is hoped that much information may be gained from such leads in coronary thrombosis"

Wolferth and Wood recommended the use of lead IV in 1932 Although this lead IV was an anteroposterior lead that is no longer in general use, it is pertinent to the discussion that follows to quote from their article 4 "It is possible that lead Il may find a place in routine electrocardi

ography '

1

Various investigators have studied the application of these leads from both an experimental and cline standpoint, and a reasonably clear con cept has been evolved concerning the normal findings in leads of this type 16 The discussion relative to the best position for the indifferent electrode as yet remains controversial, but many are entisfied that good results can be obtained by any of the methods approved by the Committee of the American Heart Association and the Cardiac Society of Great Britain and Ireland One of the main points of disagreement, however is how many precordial leads should be taken and what clinic conditions should determine the type and number of these lends. The purpose of this paper is to stress the importance of a full set of precordial leads in all cases and by presenting eramples of anteroseptal infarction to emphasize their importance in the diagnosis of this con

There are many reasons why today, even in the light of the great advances in precordial electrocardiography individuals and matitutions are tontent to secure but one precordial lead com monly lead IV F The precedent of years is difficult to break in some instances Many feel that one precordial lead of thus type gives full informa tion, despite the fact that at best, there is poor correlation between the three standard limb leads and one or two precordial tracings In many in

stances a compromise results and such leads as CF 2, CF 4, and CF 6 are taken The fallacy of such a procedure will be appreciated when the importance of a comparison of each precordial lead with that immediately preceding and follow ing it gains wider acceptance Wilson et al state.

In normal subjects the R deflection steadily increases in height as the precordial electrode is moved from the first to the fourth position and then decreases as it is moved farther to the left The decrease in the height of the R and its eventual disappearance as the exploring electrode was moved across the right side of the precordium is a far more reliable sign of infarction than complete absence of this deflection in the first two or three precordial leads "*

Others believe it both a waste of time and expense to bother with a complete precordial study Not a few after taking these leads in a fair num her of cases and seeing only an occasional in stance in which additional information has been obtained by their use, give up this practice or try to pick the case in which they believe these leads will be of value Those who attempt this short cut eventually find that the case in which full precordial leads are most necessary is usually the one in which they have been omitted

When one considers the ease with which a full set of these leads may be taken coincident with the standard set the commercially available switches that may be incorporated in any type of electrocardiograph and the slight additional time consumed in their taking, it becomes clear that such leads add little labor at the time of the original tracing Since all improve diagnostic ability through repeated experience, the ability to recognize normal precordial leads, as well as borderline variations is a rich reward for any ad ditional work. Finally most cardiologists feel that the electrocardiogram remains relatively stable over long periods. Thus normal precordial leads may assume considerable importance when later compared with subsequent tracings of the same patient which show questionable variations from the generally accepted normal findings

Thus far precordial electrocardiography has been discussed in a general manner The further purpose of this paper is to show by citation of case histories with brief concise physical findings, that the use of a single precordial lead, namely lead IV F may work to the disadvantage of the pa tient. When the electrocardiographic findings are

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given undue consideration, they may give a sense of false security to the clinician. It is believed that the use of a single precordial lead is a hazardous procedure in the case of anteroseptal infarction, but that the diagnosis can be easily established when precordial leads from the right side of the heart and intraventricular septum are incorporated with the leads from the apex

The cases selected for presentation in this report have been chosen entirely on the basis of the electrocardiographic findings. They represent the day-by-day patients seen in a consulting office and hospital practice. The findings presented have been epitomized with the purpose of relating only the essential features.

Case Reports

Case 1—A. A, a 61-year-old white man, a minister by profession, was seen on April 17, 1946, his chief complaint being extreme fatigue. The history disclosed he had a cardiac upset on February 20, 1943, which kept him in bed for one month. He gradually resumed his work and one year later had a less severe attack, necessitating one week of complete rest. Thereafter, he was able to become more active gradually. Physical examination, with particular reference to the heart, showed the sounds regular and of good quality, with no murmurs detected. There was no evidence of enlargement nor signs of congestive failure. The blood pressure was 134/78 (Fig. 1)

Case 2—B H., aged 71, a retired laborer, was seen on June 19, 1945 The chief complaint was frequent nocturnal dyspine of ten weeks' duration, which forced him to sit in a chair the greater portion of each night, usually beginning about 1 A M. His past history disclosed nothing of interest except that he had chronic indigestion for several years and took rather large quantities of baking soda daily. Physical examination, with particular reference to the heart, showed marked left ventricular enlargement, gallop rhythm, and a harsh (Grade 4) systolic murmur at the apex, with wide transmission. There were numerous moist rales at both bases but no evidence of failure of the right ventricle. The blood pressure was 124/82 (Fig. 1)

Case 3 -I G, aged 51, a mining engineer, was examined on November 11, 1946 He was doing strenuous physical work and, in addition, spending He commuch overtime in planning projects plained of nocturnal dyspnea of six weeks' dura-The attacks developed between 3 00 and 6 00 A u and were controlled in about one-half hour by sitting on the edge of his bed The history disclosed that on July 5, 1944, he had an attack of severe substernal pain, associated with weakness, profuse sweating, and the feeling of impending death He rested for three weeks and then gradually resumed his former activities During the six months preceding his present examination, he noted increasing exertional dyspnea, easy fatigue, and some weight loss Physical examination, with particular reference to the heart, showed the sounds regular, of good quality, with no murmurs detected. There was no enlargement present. There were no basal rales nor other signs of congestive failure. However, the vital capacity was considerably reduced and the sodium decholin circulation time was twenty-two seconds (Fig. 1)

Case 4-B C, an active 65-year-old physician, presented himself on November 3, 1945, with the complaints of dyspnea on slight exertion, tachycardia, easy fatigue, a developing mass in the upper abdomen, and evening ankle edema There was no history of previous or present chest pain. Careful questioning elicited the fact that three months previously, while carrying two heavy suitcases up two steep flights of stairs in a summer hotel, he was able only to make his room before being seized with sudden extreme weakness and profuse sweating The attack lasted about fifteen minutes and thereafter he was normally active He was not unduly concerned by the incident, and only with the onset of the presenting symptoms did he consider the possibility of some cardiac problem Physical examination, with particular reference to the heart, showed a rate of 120, regular, with the sounds somewhat distant and no murmurs present There was no enlargement Numerous moist rales were present at both bases The neck veins were not distended, the liver enlarged four fingers' and the legs showed 2 plus pitting edema to the knees The blood pressure was 98/80 The sodium decholin circulation time was twenty-eight seconds and the vital capacity greatly reduced Despite advice to take a few weeks' retirement, this physician continued to carry on an active practice and on digitaline nativelle, aminophyllin, and a low-salt diet made an uneventful recovery (Fig 2)

Case 5—P G, aged 44, an insurance salesman, was seen on July 3, 1946. His history showed that on May 15, 1946, he noted some difficulty in breathing while climbing one flight of stairs. This passed quickly, and after a short rest he resumed his daily activity. The next morning on arising he noted a sense of constriction in his chest, felt very weak, and became pale. He did not perspire. His attending physician kept him at bed rest for one month, and then he gradually became more active. Physical examination, with particular reference to the heart, was entirely negative. The blood pressure was 144/82 (Fig. 2)

Case 6—K. K, aged 59, a housewife, was seen at home on June 21, 1946 The history disclosed that three days previously, after running to catch a bus, she developed chest pain that radiated down the left arm. She continued on her shopping trip but felt rather weak. Two days later, while walking to church, she felt pain down the left arm. That evening she had indigestion. She attempted to walk about her home "to break up gas," but became so weak she had to call medical aid. Morphine by hypodermic and nitrogly cerin under the tongue gave her some relief. Physical examination three days later showed the heart sounds regular but weak and distant. No murmurs nor enlargement were present.

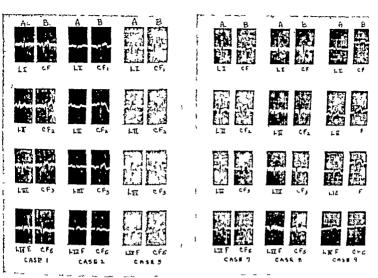


Fig 1

Figs 1, 2 and 3. The electrocardiograms reproduced in Figs 1, 2, and 3 show in Column A the commonly taken leads I II, III and IV F Those reproduced in Column B show CF 1 CF 2 CF 3 and CF 5 of the same case Examination of Column A shows suggestive myocardial changes but the diagnosis of anterosciptal infarction is made readily in each instance by the findings in Column B These findings are (1) absence of the R wave (2) frequently elevated RST segments (3) inversion of the T waves in CF 2 and CF 3 and (4) to some degree there usually are abnormal findings in CF 1 and CF 4 (L IV F) as well

Fro 3

lungs otherwise no signs of congestive failure The blood pressure was 120/74 (Fig. 2)

Case 7—J L. aged 64 a clarical employee was seen on April 29 1940 His history showed that on the way to work five weeks previously he had a peculiar feeling in his stomach and some discomfort in both arms. Two days later while he was dressing in the morning his arms began to ache and he experienced severo pain in the solar plevus area. He became weak exhausted and sweated profusely Physical examination with particular reference to the heart was negative. There was no congestive failure and the blood pressure was 164/84 (Fig. 3)

Case 8—J P aged 61 a molder by trade was seen on June 7 1943. His complaints were that after walking one quarter mile at his camp he experienced a band like constriction in his chest. He rested and on resuming his walk became weak mauseated, and perspired profusely. There was no sensation of pain Physical examination with particular reference to the heart showed distant apical sounds but no congestive failure. The blood pressure was 130/74 (Fig. 3)

Case 9 -A D, aged 54, a village grocer, was seen on January 23, 1947 The main facts in the history were that he had had considerable indigestion over a three-year period, usually relieved promptly by a dosage of baking soda For six months preceding his acute attack, he had noted chest pain of brief duration on exertion This always reacted favorably to rest At about 2 00 AM on the day he was seen, he awakened with severe chest pain and rapidly went into shock He was admitted to the hospital and on examination fourteen hours later was much improved His color was good There was no dyspnea and the heart sounds were of fair quality, no congestive failure was present. The blood pressure was 112/84 (Fig 3)

Case 10 -A S, aged 49, plant foreman, experienced chest discomfort late in the afternoon on March 7, 1947 He rested a short time and then left the plant and drove his car home. The pain persisted during the early evening, but he rested well all night and returned to work for four more days. The pain recurred on March 11 An electrocardiogram was taken at the plant, and he was advised that myocardial damage was present. He was seen at the office on March 21 There were no complaints at that time Physical examination, with particular reference to the heart, was negative The heart sounds were of good quality, with no murmurs detected nor evidence of enlargement The vital capacity was considerably reduced, and the blood pressure was 120/80 This case is presented so that serial electrocardiograms may be introduced to show that, as in other types of myocardial infarction, a considerable period of time may elapse before typical changes of anteroseptal infarction appear in the tracing (Fig 4)

Discussion

The purpose of presenting these cases of anteroseptal infarction has been to stress the importance of taking routinely the precordial leads CF 1 through CF 4 in all instances of suspected coronary disease By similar reasoning, an equally good case could be made for anterolateral infarction to stress the necessity of continuing these precordial leads through at least CF 5 and CF 6 The work of Wood et al * indicates, however, that a definite clue to this latter condition may be found frequently from charactenstic changes appearing in the three standard leads and lead IV F To date, however, I am unaware of any similar assistance from these leads in the diagnosis of anteroseptal infarction However, some of the tracings studied and considered typical of anteroseptal infarction show the T wave in lead 1 less prominent than T3 Dressler has noted this finding in a series of 45 cases reviewed by him in 1943 10 He felt, except in specific exceptions, that this sign was often diagnostic of antenor infarction and most valuable when the commonly accepted criteria for this condition was absent in the usual 4 lead electro-

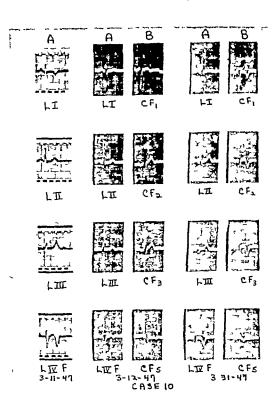


Fig. 4 The tracing on March 11, 1947 shows small Q1 with inverted T1, high T3, small Q4 with normal R4, and deep, coved inverted T4. The tracing on March 12, 1947, with precordial leads (Column B), shows T1 now upright, T3 less voltage, R4 higher, and slight late inversion of T4. CF 1, CF 2, and CF 3 are not remarkable, and CF 5 shows T wave inversion. The tracing on March 31, 1941, shows little change in lead 1, R2 is less tall, QRS 3 is smaller with bifid R waves, and T2 and T3 shows increased voltage. Lead IV F shows normal R with deep inverted T4. Leads CF 1, CF 2, and CF 3 show absent R waves and deep coved inverted T waves The T wave is inverted in CF 5. These serial tracings show that diagnostic signs of anteroseptal infarction may be delayed in their appearance.

cardiogram As reports accumulate, it is possible that finding T1 of less voltage than T3, and with lead IV F nondiagnostic, may prove helpful in suggesting the possibility of anteroseptal infarction

In this series of cases, fever and the more common laboratory procedures, sedimentation rate and white blood count, were characteristic of infarction in general ¹¹ In a total of 27 reviewed cases, only one feminine patient was found to have definite diagnostic signs of this condition. No patient has died up to the date of this report and this fact remains true despite the advanced cardiac failure as shown in several instances. All of these patients have responded well to accepted treatment of acute congestive failure. Blumgart and his associates have shown that the role

of the particular vessel occluded, and its relation to the general blood supply of the heart, is of great importance 12 It may be possible that these cases fall into the favorable 40 per cent group with nght coronary artery predominance There have been no irreversible complications and, once the diagnosis of anterosoptal infarction has been established the prognosus is good. This finding has considerable clinic importance since it is well known that patients with either anterior or posterior infarction are subject to sudden, un explained death even when they are considered to be well on the road to recovery

From the above data it would appear both reasonable and wise to accept the procedure of routinely taking precordial leads CF 1 through CF 4 and presumably helpful to continue through at least CF 6 in all cases of possible acute my ocar dial infarction The wisdom of following this same procedure in cases giving a history of chronic myocardial infarction appears substantiated equally well by the observations cited above

Conclusions

- The value of routine precordial leads CF 1 through CF 4 is established
- Evidence to show that anteroseptal infarction may pass unrecognized without these leads has been presented

- In this limited series of cases only one female patient has been found with anteroseptal in farction
- The prognosis in this type of infarction appears excellent
- It is strongly recommended that a full set of precordial leads rather than variations of CF 1 through CF 0 be taken in all cases of suspected mvocardial infarction

It is a pleasure to acknowledge the courtesy shown by Dr Frank N Wilson University Hospital Ann Arbor Michigan in reviewing both the manuscript and the electrocardiograms reproduced in this article.

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RESEARCH FELLOWSHIPS IN MEDICINE AWARDED

Announcement is made of the Research Fellow ships in Medicine which have been awarded by the American College of Physicians for the year be-siming July 1048 The College makes available each year a limited number of these fellowships with stupends ranging from \$2,200 to \$3,200 the purpose of which is to give to young physicians, who are preparing for an academic career in internal medicine or pediatrics an opportunity to have a year of investigative experience as an early part of their preparation

The Board of Regents of the College, on the nomination of the Committee on Fellowships and Awards awarded six Research Fellowships in Medicine at their meetings in Philadelphia on November 22 and 23 1947

He is at present resident in medicine in the Duke University Hospital With the aid of the fellowship Dr Martin will undertake studies of bacterial metabolism in the Rockefeller Institute for Medical Research, New York City under the direction of Dr René J Dubos

The awards included—for research in New York

City-Dr Samuel P Martin Durham North Caro-

Dr Martin's premedical and medical courses were taken at Washington University St Louis where he received the MD degree in 1941. He

interned in the Barnes Hospital St Louis 1942-

1948 and served there also as assistant resident in medicine 1943-1944 Dr Martin served in the

U.S Army from 1944 until 1947

lına

A PRELIMINARY REPORT ON A NEW AND SIMPLIFIED PENICILLIN VEHICLE

M J GOODFRIEND, M D , F A C S , I C Fischer, M D , and L J Caruso, M D , New York City

(From the Obstetrical and Gynecological Service of the Morrissania City Hospital)

SINCE the advent of penicilin many methods have been devised for the prolongation and maintenance of therapeutic blood levels without the necessity of injections at three-hour intervals. These have been limited to two forms (1) retarding the rate of absorption, and (2) diminishing the rate of excretion from the body.

The present report of a technic used in parenteral administration of penicillin at the Morrissania City Hospital is a preliminary one. In the study submitted it was not our intention to determine the antibiotic activity of penicillin, but rather to determine whether we could obtain therapeutic blood levels and maintain them for varying periods of time without increasing or producing side-effects. For the purpose of this study we used a new and simplified solvent, commercially called Solvecillin*, a prepared emulsion of cholesterol esters containing one per cent by weight of beeswax, as a vehicle for the use of crystalline penicillin

Seventy patients were chosen without any known renal pathology. Twenty of these were given 100,000 units in 2 cc of prepared emulsion, 35 patients were given 200,000 units in 2 cc of prepared emulsion, and 15 patients were given 500,000 units, of these, eight received the dose in 3 cc of prepared emulsion, and for the remaining seven, 4 cc of the solvent were used

Technic

The designated amount of prepared emulsion was injected into a vial of penicillin, which was agitated slightly, and the contents withdrawn into a syringe with a No 20-gage needle. The emulsion was then injected intramuscularly into the gluteal muscle in the usual manner. Blood was taken at intervals from four to twenty-four hours after injection. The blood samples were assayed according to the method prescribed by the Federal Food and Drug Administration. The findings are submitted herewith

The 20 patients using 100,000 units of penicillin with 2 cc of the vehicle were found to have a blood level of 0 19 units at the end of four hours, 0 15 units at the end of six hours, 0 10 units at the end of eight hours, 0 08 units at the end of ten hours, and 0 06 at the end of twelve hours (Fig 1) The 35 patients using 200,000 units of penicillin with 2 cc of the vehicle were found to have blood levels of 0 39 units at the end of four hours,

0 12 at the end of eight hours, 0 1 at the end of ten hours, 0 09 at the end of twelve and sixteen hours, 0 06 at the end of eighteen hours, 0 04 at the end of twenty hours, and 0 025 at the end of twenty-four hours

With 500,000 units of penicillin, the average blood levels at the end of twenty-two and twenty-four hours were 0.09 units

Comment

With the use of the prepared emulsion we have been able to demonstrate that, in order to maintain constant and therapeutic blood levels for prolonged periods, only one injection a day was required instead of divided doses of eight injec-

Allergic reactions were negligible A mild urticarial rash was observed in only one subject of the seventy injected, and this was overcome with the use of benadryl

No abscesses or foreign body reactions were observed in any of the 70 patients

Summary

1 This prepared emulsion as a vehicle offers a satisfactory method for prolonging the action of and retarding the excretion of penicillin

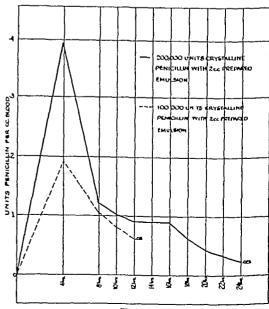


Fig 1

- With 100,000 units of penicillin used, a blood level of 0 06 units was maintained at the end of twelve hours. With 200,000 units of penicillin, a concentration of 0 025 units was maintained at the end of twenty-four hours which is sufficient for the majority of cases requiring the drug
- 3 In those conditions where a greater concentration of penicillin in the blood is required, 500,000 units of penicillin in the emulsion meets the necessary requirements, since at the end of

twenty four hours α blood level of 0.09 units is still present

- 4 Since therapeutic levels are obtained with rapidity and maintained with one injection per day, a considerable reduction in nursing effort is obtained
- 5 A simple and economical method of prolonging the action of penicillin is presented

New and simplified Bolvecillin was courteously supplied by Polvecillin, Inc. Newark, New Jersey

CANCER MOBILE

The farmer's wife with the lump in her breast, the village store clerk whose voice has dwindled to a beans whisper—no longer need they go without examination for months and live in the fear that

they may have cancer

A new weapon, forged by the Kentucky division
of the American Cancer Society with the aid of the
Oeneral Electric X Ray Corporation has made it
possible for people in outlying areas, where doctors
and x-ray facilities are few to receive first-class
medical examination for cancer without the cost
and difficulty.

and difficulty of traveling great distances.

This weapon is the first mobile cancer detection bus ever to be equipped with x ray apparatus.

Modeled after buses now used for x ray surveys of apparently healthy persons in tuberculosis campaigns, the cancer bus, known officially as the Cancer Mobile, will carry x-ray into the byways of Kentucky acting as an extension arm of the states widespread network of 16 cancer clinics.

Primary purpose of the unit will be to provide free examination for suspected cases among those unable to pay. But, in addition, doctors who do not have ray facilities may also use the apparatus in the bus for their private patients

To insure the fullest utilization of the bus and offer diagnostic facilities, the cancer organization has under way an intensive program of education. This is designed to increase the public s awareness

of warning symptoms and to stress the importance of routine periodic medical examinations.

The versatile x ray unit with which the bus is outfitted features one x ray tube that is capable of two types of examinations—radiography (the making of x ray films) and fluorescopy (the study of the body organs in motion by the physician). A special device is provided to hold films so that chest x rays can be taken in an upright position.

Also incorporated into the bus is a darkroom for developing x-ray film, a dressing booth, and a special laboratory table for examining blopsy specimens (sections of living discus which can be studied under the microscope to dottermine malignancy)

The bus will go only to counties which extend a formal invitation through their county medical societies. After arrangements have been made to have the unit go to a particular county members of the medical society and other groups will be asked to volunteer assistance at the diagnostic clinic

At the same time, while the unit is in the county educational programs will be presented to lay groups on cancer control. Movies will be shown and ratio stations will be asked to carry live-speaker programs.

Arrangements will be made with the cooperating medical society to have a meeting of its members during the time the cancer clinic is held. At this time a scientific program will be presented by clinic staff members on cancer diagnosis and treatment

FIXED EXTENSION OF THE KNEE DUE TO CAPSULAR CONTRACTION

LEWIS CLARK WAGNER, MD, New York City

(From the Hospital for Ruptured and Crippled)

THE contraction of the supporting ligaments and the capsule of any joint in the body may become evident after trauma, infectious processes, or prolonged immobilization ending in limitation of motion and function of the articulation or articulations of the part involved. The knee is apparently the one articulation in which loss of motion gives the greatest disability, because of the special function desired of it in locomotion and the necessity for its being out of the way in the sitting position.

Bennett has described a technic of quadriceps tendon lengthening in primary shortening of the quadriceps femoris muscle which has yielded good results ¹

Thompson has described an operation for scarring of the vasti muscles with freeing of the affected muscles and removal of part of the vastus intermedius without section of the rectus femoris tendon, which has yielded good results in many cases ²

The treatment of such cases which are presented in this paper is section of the contracted capsule of the joint (assuming there are no bone changes in the articulation of the knee apparent in the x-ray examination) associated with elongation of the quadriceps tendon

These case histories concern individuals in whom the primary cause of fixation of the knee was capsular contraction. The shortening of the quadriceps apparatus was a secondary factor.

Operative Technic

A tourniquet is applied to the thigh and the knee is prepared and draped in the usual manner, as the surgeon desires A long, median parapatellar incision is made about 9 inches long, extending from the tibial condyle upward, exposing the capsular ligaments and the quadriceps The skin is reflected both medially and laterally, exposing the anterior capsular struc-The quadriceps tendon is tures of the knee joint divided in an inverted V-shaped incision, about 4 inches above the patella, separating the tendon from the medial and lateral vasti muscles incision is then carried lateral and medial to the patella through the capsular ligaments, fanning laterally to the superior margin of the semilunar cartilages in the region of the lateral and medial

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Orthopedic Surgery, May 9 1047

ligaments of the knee The flap, consisting of the sectioned quadriceps tendon, the patella, and the incised capsular ligaments, is reflected downward and the knee flexed over the table to an angle of 90 degrees The flap is replaced, and the capsular ligaments and the quadriceps tendon are sutured in the new position, with the knee flexed to 90 degrees, which allows for about 2 to 3 inches of lengthening of the quadriceps tendon If the capsular ligaments cannot be closed, duplications of the capsule can be separated to draw over the unclosed capsular separation is closed in the usual manner and plaster of paris dressing is applied from the groin up to and including the toes, with the knee flexed to 90 degrees

Postoperative Treatment

Ten to twelve days after operation the wounds are dressed, and the sutures are removed this time there is considerable swelling about the knee, but the limb is nevertheless placed in a suspended splint with a movable knee attachment With the aid of pulleys and rope, the knee is passively pulled from an angle of 90 degrees to complete extension, as much as the patient can endure without discomfort These exercises are carried out for a period of two weeks when the patient is usually ready for ambulation with the aid of The patient is encouraged to walk with daily visits to the physiotherapy department for pool treatment, if available, and muscle reeducation by passive exercises to retain the range of motion secured at operation Progress is slow, but the patient soon regains his confidence, and, as strength is recovered in the quadriceps muscle, support can be discarded Low heel shoes are necessary to give stability to the limb final effect of after-treatment can be expected in one to two years

Case Reports

Case 1—Charles S, aged forty-seven, was admitted to the Hospital for Ruptured and Crippled, June 27, 1927 The patient had a malunion of the femur at the junction of the upper and middle thirds with 4 inches overriding. Open reduction was performed. The site of the malunion was broken up, the fragments freed, the wound closed, and a Steinmann pin was placed through the condyle region. Traction was applied, followed by application of plaster two months later which remained on until September 23, 1927

The patient was readmitted to the hospital on January 4, 1929 The fracture site had united with no deformity The knee was fixed in extension with only a few degrees of motion in the knee joint X-ray showed no narrowing of the joint space of the knee. On January 5 1929 elongation of the quadriceps tendon was brought about by the Bennett procedure Only about 40 degrees of motion could be secured On February 1 1929 under other anesthesia the knee was manipulated and flexed to a right angle. The wound was completely broken open, and it was noted that the capsule had broken obliquely. The wounds were drawn together and plaster applied with the leg at a right angle. Four weeks later the plaster was removed and a splint applied with a joint at the knee for exercising. On March 19 1929 the patient was walking about. The knee could be fleved to a right angle and extended to about 145 degrees The patient continued active physiotherapy and stretching and on April 29 1020 walked with freedom using a cane on the right aide. The knee could be flexed to 90 degrees and extension was possible to 165 degrees with forcible extension to 180 degrees

Examination three years later showed the patient walking without a limp He had active extension to 170 degrees and flexion to 90 degrees and was very well satisfied with the result

Case 2—Shirloy L. aged twenty four, was admitted to the Hospital for Ruptured and Crippled on January 3 1020. The patient had previously had a general arthritis with resultant loss of motion in the left knee but no pain Examination at the time showed extension to 180 degrees and a range of flaxion of about 15 degrees.

On January 4 1929 under general anesthesia an attempt was made to move the knee by forcible manipulation, but this was impossible. The patient was discharged from the hospital and returned on May 19 1929 At that time using a tourniquet the quadriceps tendon was explored and divided according to the Bennett procedure No motion could be secured in the knee Lateral incusions were then extended close to the patella across the capsule of the knee joint fanning laterally to the attachment of the lateral ligaments. The knee could then be forcibly flexed to a right angle The capsule of the joint was sutured and the patellar tendon was resutured allowing about 3 inches lengthening The skin was closed in the usual manner and plaster applied from the groin to the ankle with the knee flexed at 90 degrees. Three weeks later, when the wounds had healed the patient was placed in suspension and traction and both active and passive motion was started. At the end of the fifth week, she was walking with the aid of crutches and receiving active physiotherapy The patient when discharged from the hospital on July 15 1929 had passive extension to 180 degrees, setive extension to 140 degrees, and flexion to a right angle. The patient was carried along for another six months on active physiotherapy which consisted of massage to the quadriceps area and active motion to the knee

Seventeen years later the patient walked without a limp. She had extension to 175 degrees actively and to 180 degrees passively, with flexion through an arc of about 95 degrees. There was no pain no weakness and no limp.

Case 3 -Geoffrey B aged forty three was ad mitted to the Hospital for Ruptured and Crippled, January 8, 1936 The patient gave a history of hav ing been perfectly well until November 1934 when he began to have pain, swelling and stiffness in both knees. A diagnosis of hypertrophic synovitis was made 1 rays showed no bone changes about either knee joint. A synovectomy of the right knee was performed on June 9 1938 and on the left knee on June 25 1936 The course following the operation was uneventful, but the patient had little or no motion in either knee. He was carried on active physictherapy but no motion could be secured and the patient was very much disabled On October 13 1936 both knees were manipulated under anesthesia only a few degrees of motion were secured. The patient was so incapacitated because of the stiff knees that something had to be done to make walk ing less difficult for him, although he had no pain. Since the right knee had about 15 or 20 degrees of motion and the left knee had none the latter was relected for operation

On January 23, 1937 the knee was explored, and the quadriceps tendon elongated according to the Bennett technic, but it was impossible to flex the knee Parallel incisions of the patella were made and the natella elevated. Still no motion could be secured because of the capsular contraction When the capsule was divided obliquely the knee could be flexed to a right angle The wounds were closed, lengthening the quadriceps tendon about 2 inches and approximating the capsule as well as possible A plaster of paris dressing was applied with the knee at a right angle and was removed at the end of three weeks. The wound healed the patient put in a splint and active manipulation of the knee was started The splint was removed at the end of three weeks the patient being carried on at the physictherapy department for the next eight months.

Examination on June 29 1039 showed the left knee to have active extension to 168 degrees and flexion to 70 degrees. The knee could be extended passively to 180 degrees. There was no swelling and the patient had no complaints. The right knee which was not operated upon, had only a few degrees of motion. There was no pain and the patient was satisfied with the result.

Case 4.—Frances E. aged thirty four was ad mitted to the Hospittal for Ruptured and Crippled June 16 1937 For the past two years the patient lad marked swelling of the right knee. She had had a thorough study and tuberculosis was ruled out It was considered a case of hypertroplue synovitis. At that time the patient had a range of motion from 180 degrees extension through an arc of 90 degrees flexion. A synovectomy of the right knee was per formed and the patiella was removed because of changes in the cartillaginous surface. Following the operation the wound healed satisfactorily and the patient was walking on the tenth day. She was sent

ular, the deformity is usually a flexion rather than an extension contracture—If there is coexisting intra-articular pathology of severe degree, little, if any, improvement will be obtained by this procedure alone

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son quadricepsplasty

I believe Dr Wagner's procedure augments the Bennett procedure in that it releases the constricting components of the fibrous capsule itself, as well as moderately lengthening the shortened quadriceps Dr Thompson's procedure presupposes no permanent secondary shortening of the quadriceps mechanism and is applicable to recently developed

dense adhesions between the components of the quadriceps mechanism, particularly the vastus intermedius and the femur. In other words, careful evaluation of the primary pathology is necessary before choice of procedure is made. The choice may be impossible before the capsule and quadriceps mechanism are exposed surgically.

One cannot emphasize too strongly the diligent follow-up care stressed by Dr Wagner, whose cases, with such care, show that they "improve with age" The patient's mental attitude is of equal importance

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ARMY SURGEON GENERAL ANNOUNCES IMPROVEMENTS IN ADVANCED TRAINING

Major General Raymond W Bliss, Surgeon General of the Army, recently announced adoption of a number of changes in the Army Medical Department graduate professional education program for the coming year based on a thorough study of mine months' operation of the program and surveys made by nine teams of civilian medical experts

The innovations, effective immediately, are designed to maintain the quality of patient care and to elevate the caliber of training at Army general hospitals. As announced by General Bliss, the

major changes are as follows

Graduate training in psychiatry is being strengthened and concentrated in three general hospitals— Letterman (San Francisco), Fitzsimons (Denver), and Wal er Reed (Washington, D.C.) This plan will afford each resident more individual instruction

Many qualified civilian consultants will be added to the attending staffs of the hospitals which are engaged in teaching. These will be distributed among the various special fields of medicine and surgery in which the Army is training residents

and interns

The administrative responsibilities of qualified teachers will be lessened by the transfer of routine paper work to administrative assistants assigned from the Medical Service Corps This will allow the professional instructors to devote the major portion of their time to teaching and to the care of patients

Qualified instructor personnel will be kept on duty in their present assignments for as long as possible. When it becomes necessary to move them, they will be placed in such locations as to enable them to teach so that maximum utilization can be made of their experience and ability

Special instruction in the best methods of medical education is being provided for key military instructor personnel by means of short courses at selected civilian medical teaching institutions

The number of conferences at which attendance by all residents and interns is required is being reduced. Where possible, these will be held at such times as will not interfere with bedside teaching Likewise, the administrative duties of student officers are being reduced to the bare minimum consistent with excellent care of patients under their supervision.

More adequate means of resident-intern selection, and evaluation of progress, are being placed in operation. Personal interviews will receive special emphasis. Individual evaluations will be made of student officers by the civilian instructors as well as by the regularly assigned chiefs of services and sections at the teaching hospitals.

The actual content of the program of instruction for each special field will be developed in more de-

tail

Portions of the program will be delegated to the military or civilian instructor who is best qualified in each particular phase, so that accurate and complete coverage will be obtained within the residency span

Finally, the present obstacles in the organization of interns and residents into the accepted pyramidal system are being overcome, so that the student officers may be given increased responsibility in care of patients, teaching, and the supervision of others, as they progress from one year of training to the next

TEAR OF THE LATERAL LIGAMENT OF THE ANKLE

LOUIS A GOLDSTEIN M.D., Rochester New York

(From the Department of Surgery Duranon of Orthopedies University of Rochester School of Medicine and Dentistry)

A NEGATIVE routing roentgenographic examination of a sprained ankle does not rule out a serious injury. In the more severe sprains of the ankle, a complete rupture of the lateral ligaments must be suspected. On clinical exsmination, one can suspect a ligament tear the diagnosis can be definitely established by roentgenograms taken with inversion stress applied to the foot The evaluation of the degree and severity of lateral ligament tear offers no problem if one takes advantage of the informa tion gained by roentgenographic study under inversion stress. On the other hand the treatment indicated is not always so clearly defined What is the treatment of choice? Is plaster cast unmobilization necessary for optimum healing and stability? If so, how long need immobili ration be continued? Is firm adhesive strapping adequate? Is novocaine injection and early weight bearing good treatment?

The lateral ligament of the ankle joint consists

of three fasciculi

1 The anterior fasciculus or anterior talofibular ligament

2. The lateral fasciculus or calcaneofibular ligament

The posterior fasciculus or posterior talofibular ligament.

The lateral ligament components stabilize the talus in the mortise preventing tilt of the talus when inversion stress is applied to the foot Rupture of one or more of the fasciculi of this ligament allows the talus to tilt. The degree of tilting or subluxation depends upon the degree of tear of the lateral ligament structures.

Observations on postmortem specimens in which the lateral ligament components were revered singly and in various combinations are reported elsewhere. It was found that cutting one or two fasciculi resulted in less than a 15 decree tilt of the talus. When all three components of the lateral ligament and the adjacent iont capsule were severed a 30 degree or greater tilt resulted.

The diagnosis of tear of the lateral collateral brament of the ankle joint cannot be made with cartaints on the basis of clinical signs. In our experience however, the clinical examination

Prevailed at the 141st Annual Meeting of the Medical County of the State of New York Buffalo Section on Orthobedier Surgery May 8, 1947 serves as a reliable guide in choosing those cases warranting examination under inversion stress

In sovere sprains lateral ligament rupture should be suspected The history of something "snapping" 'giving way," or "slipping out of place" is significant. In the absence of a fracture on routine roentgenograms these subjective symptoms are highly suggestive of ligament rup-When the injured andle is seen within an hour or two after injury, there may be little objective evidence of severe injury. During this early period tenderness and swelling on the medial aspect of the ankle over the deltoid high ment is an important sign. With complete rupture of the lateral ligament there is a temporary dislocation of the tilus and resultant injury to the deltoid ligament while no deltoid ligament trauma and no swelling or tenderness on the medial side of the ankle joint are evident in sim During the first few hours, a fairly well circumscribed awelling forming a semicircle around the tip of the fibula with tenderness at the points of origin of the lateral ligament, may be present. In other cases, there is an egg shaped, localized swelling largely below the tip of the fibula becoming diffuse and marked subsequently Ecohymosis is usually present and tenderness is maximum in the region of the Interal ligament components Tenderness of the distal tibiolibular joint, indicating some damage to these ligaments is a constant finding

In one group of cases examined over a four month period, data were kept on the number of positive and negative results of inversion stress examinations. Forty-one ankles were subjected to inversion stress under anesthesia for roentgenographic examination. Twenty nine of these examinations showed 30 or more degrees of talar tilt indicating complete tear of the lateral ligament of the ankle, seven showed less than a 30-degree talar tilt indicating meomplete tear of the lateral ligament, five showed no abnormal talar mobility. Thus 36 out of 41 cases were positive.

Routine anteroposterior and lateral reentgeno grams are taken. Those cases in which the ankle joint shows no fracture or mortise spread and in which the clinical examination reveals lateral ligament tenderness of definite or questionable significance, are examined reentgenographically ular, the deformity is usually a flexion rather than an extension contracture. If there is coexisting intra-articular pathology of severe degree, little, if any, improvement will be obtained by this procedure alone

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Many qualified civilian consultants will be added to the attending staffs of the hospitals which are engaged in teaching. These will be distributed among the various special fields of medicine and surgery in which the Army is training residents and interns.

The administrative responsibilities of qualified teachers will be lessened by the transfer of routine paper work to administrative assistants assigned from the Medical Service Corps. This will allow the professional instructors to devote the major portion of their time to teaching and to the care of patients.

Qualified instructor personnel will be kept on duty in their present assignments for as long as possible. When it becomes necessary to move them, they will be placed in such locations as to enable them to teach so that maximum utilization

can be made of their experience and ability
Special instruction in the best methods of medical education is being provided for key military
instructor personnel by means of short courses
at selected civilian medical teaching institutions

The number of conferences at which attendance by all residents and interns is required is being reduced. Where possible, these will be held at such times as will not interfere with bedside teaching Likewise, the administrative duties of student officers are being reduced to the bare minimum consistent with excellent care of patients under their supervision.

More adequate means of resident-intern selection, and evaluation of progress, are being placed in operation. Personal interviews will receive special emphasis. Individual evaluations will be made of student officers by the civilian instructors as well as by the regularly assigned chiefs of services and sections at the teaching hospitals.

The actual content of the program of instruction for each special field will be developed in more de-

Portions of the program will be delegated to the military or civilian instructor who is best qualified in each particular phase, so that accurate and complete coverage will be obtained within the residency span

Finally, the present obstacles in the organization of interns and residents into the accepted pyramidal system are being overcome, so that the student officers may be given increased responsibility in care of patients, teaching, and the supervision of others, as they progress from one year of training to the next

TEAR OF THE LATERAL LIGAMENT OF THE ANKLE

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NEGATIVΓ routine reentgenographic ex Λ amination of a sprained ankle does not rule out a serious miury In the more severe sprains of the ankle, a complete rupture of the lateral ligaments must be suspected. On clinical examination, one can suspect a ligament tear the diagnosis can be definitely established by roentgenograms taken with inversion stress applied to the foot The evaluation of the degree and severity of lateral ligament tear offers no problem if one takes advantage of the informa tion gained by roentgenographic study under inversion stress On the other hand the treatment indicated is not always so clearly defined What is the treatment of choice? Is plaster cast immobilization necessary for optimum healing and stability? If so how long need immobili ration be continued? Is firm adhesive strapping adequate? Is novocaine injection and early weight bearing good treatment?

The lateral ligament of the ankle joint consists

of three fasciculi

1. The antenor fasciculus or anterior talofibular ligament

2. The lateral fasciculus or calcaneofibular

ligament
3 The posterior fasciculus or posterior talo-

fibular ligament.

The lateral ligament components stabilize the talus in the mortise preventing tilt of the talus when inversion stress is applied to the foot Rupture of one or more of the fasciculi of this ligament allows the talus to tilt. The degree of tilting or subluxation depends upon the degree of tear of the lateral ligament structures

Observations on postmortem specimens in which the lateral ligament components were wered singly and in various combinations are provided elsewhere. It was found that cutting one or two fasciculi resulted in less than a 15 degree tilt of the talus. When all three components of the lateral ligament and the adjacent point capsule were severed a 30 degree or greater tilt resulted.

The diagnosis of tear of the lateral collateral ligament of the anale joint cannot be made with extrainty on the basis of clinical signs. In our expenence however, the clinical examination

Prevaled at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo Section on Orthopolic Surgery May 8, 1917 serves as a reliable guide in choosing those cases wirranting examination under inversion stress

In sovere sprains lateral ligament rupture should be suspected. The history of something "snapping" 'giving way," or "slipping out of place ' is significant. In the absence of a fracture on routine roent enograms these subjective symptoms are highly suggestive of ligament rup-When the injured ankle is seen within an hour or two after injury, there may be little obsective evidence of severe insury. During this early period tenderness and swelling on the medial aspect of the ankle over the deltoid ligament is an important sign With complete rupture of the lateral beament there is a temporary dislocation of the talus and resultant injury to the deltoid ligament while no deltoid ligament trauma and no swelling or tenderness on the medial side of the ankle joint are evident in simple sprains During the first few hours, a fairly well circumscribed swelling forming a semicircle around the tip of the fibula with tenderness at the points of origin of the lateral ligament, may be present. In other cases, there is an egg shaped localized swelling largely below the tip of the fibula, becoming diffuse and marked subsequently Ecclymosis is usually present and tenderness is maximum in the region of the Interal ligament components Tenderness of the distal tibiolibular joint, indicating some damage to these ligaments, is a constant finding

In ne group of eases examined over a four month period data were kept on the number of positive and negative results of inversion stress examinations. Forty-one ankles were subjected to inversion stress under anesthesia for coentgenographic examination. Twenty nine of these examinations showed 30 or more degrees of talar tilt indicating complete tear of the lateral ligament of the ankle, soven showed less than a 30-degree talar tilt indicating incomplete tear of the lateral ligament, five showed no abnormal talar mobility. Thus 36 out of 41 cases were positive.

Routine anteropostonor and lateral roontgeno grams are taken Those cases in which the ankle joint shows no fracture or mortise spread and in which the clinical examination reveals lateral ligament tenderness of definite or questionable spriftcance, are examined roontgenographically

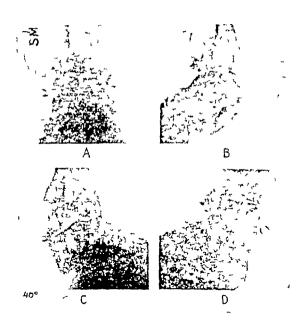


Fig 1 Case of complete tear of the lateral ligament of the ankle in a forty-eight-year-old volunteer Red Cross worker — Inversion injury sustained when she stepped off a loading platform — A, B, Routine anteroposterior and lateral views of the ankle showing no fracture of mortise abnormality C, Under general anesthesia (sodium pentothal) inversion stress examination shows a 40-degree tilt of the talus — D, Inversion stress examination of the uninjured ankle shows no tilt of the talus

under inversion stress The uninjured ankle is examined under stress for comparison to note the normal range of talar mobility

The patient is anesthetized with sodium pentothal on the x-ray table with the lower extremities exposed to the midthigh The foot is forcibly inverted by grasping the forefoot with one hand and applying counter pressure against the distal third of the leg with the other hand With the foot in maximum inversion and the knee in a true anteroposterior plane a roentgenogram of the ankle is taken The same maneuver is repeated on the uninjured side and the negatives developed immediately Subluxation of the talus is frequently palpable and visible during the inversion maneuver in cases of complete lateral ligament tear, noted only with 30 or more degrees of talar tilts A complete rupture of the three components of the lateral ligament allowing the talus to sublux slightly posteriorly as well as tilt into varus is also indicated by this Undue force need not be applied, but the inversion maneuver improperly performed will not give a true picture of the degree of injury (Fig 1)

The cases that showed a greater than 15 degree tilt of the talus on roentgenographic examination under inversion stress were immediately immobilized in a circular, below-the-knee

plaster of paris cast with the foot at 90 degrees dorsifiexion in neutral version. Normal ankles usually show less than a 5 degree tilt of the talus under inversion stress, although occasionally as much as 10 degrees is observed.

In recent ankle injuries, because of pain and sensitivity, the extent of injury to the lateral ligament is evaluated best under anesthesia Although general anesthesia is ideal for inversion stress examination, the injury can be satisfactorily evaluated under local anesthesia. About 25 cc of novocaine are injected into the hematoma or region of the lateral ligaments, the examination being made after a lapse of twenty minutes. Because of peroneal muscle spasm the tilt of the talus can be expected to be ten to twenty degrees less than when the test is done under general anesthesia (Fig. 2)



Fig 2

Discussion

The diagnosis of tear of the lateral collateral ligament of the ankle joint can be suspected in certain "ankle sprains" Since routine anteroposterior and lateral roentgenograms are negative, the diagnosis can be established only by roentgenographic examination of the ankle under inversion stress

Correct diagnosis and adequate treatment at the time of injury will prevent the symptoms of an unstable ankle The usual mobilizing regime for the treatment of a simple ankle sprain is not good treatment for ruptures of the lateral ligament of the ankle Particularly contraindicated is the treatment of severe "ankle sprains," frequently having tears of one or more fasciculi of the lateral collateral ligament of the ankle, by local novocaine injection and early unprotected weight bearing Relief of pain, resulting from the novocaine injection, makes possible and encourages a degree of activity which is detrimental to the healing of the torn ligaments Immobilization, prolonged and continuous, rather than mobilization, is required for healing of the ligaments and a stable ankle

A total of 55 cases (51 cases in soldiers, 4 cases in civilians) of complete tears of the lateral collateral ligament of the ankle joint were diagnosed by roentgenographic examination of the ankle with inversion stress under anesthesia

In a group of 101 acute ankle sprains seen in an Army general hospital during a four-month period, 29 cases showed complete tears of the lateral ligaments of the ankle. Forty-one of this group of 101 were subjected to roentgenographic examinations under inversion stress. The other 60 ankles were relatively mild sprains and were not suspected of ligament rupture. In this group of soldiers 28 per cent were found to have complete rupture of the lateral ligament.

There is some difference of opinion in regard to the duration of immobilization required for complete healing of the torn ligaments rlod from ax to ten or twelve weeks has been recommonded Watson-Jones states that a mini mum of ten weeks' immobilization is required on the basis that "union is not sound unless im mobilization has continued for at least ten Even after that time slight tilting may persist, but only within the limits capable of control by muscle power" In a report on "Rehabilitation in the ETO ' the following statement is made regarding 25 cases of rupture of the lateral ligaments of the ankle "Immobilization in plaster for six to eight weeks is the method of choice All were returned to full duty diagnosed cases resulted in serious incapacity ' We have recommended an eight-week period of immobilization for the patients in whom we initiated treatment The author has continued this practice in civilian patients In a young, vigor ous man or woman who is interested in a strong and stable ankle the most desirable treatment, in the author's opinion, is plaster cast immobili ration for an eight-week period In the patient over forty years of age who is not engaged in competitive athletics or other vigorous types of activity requiring perfect ankle stability, ankle strapping may be adequate treatment. The strapping should be continued for a six to-eightweek period

Follow-up inversion stress examinations have been obtained in 5 cases In 4 instances there was no residual tilt of the talus on roentgenographic examination under inversion stress These cases showed 20-, 22- 30-, and 40-degree tilt of the talus on the initial examination fifth case showed a residual 15-degree talar tilt four months after the injury, having been a 45degree tilt originally The uninjured ankle in this case also showed a 15-degree tilt of the talus on inversion stress examination. The follow-up examinations were performed without anesthesia from three to nine months after injury thesia is not required for evaluation of residual bgament laxity because there is no longer any acute sensitivity of the lateral ankle structures

What happens to the lateral ligament ruptures that are not recognized and are treated as simple ankle sprains? Failure to immobilize lateral ligament ruptures results in failure of the ligament to heal or in healing in a relaxed position

The clinical significance of this abnormal talar mobility depends upon the ability of the individual to compensate for the loss of the stabilizing ligaments by peroneal muscle function. Incomplete ligament tears with talar tilts of less than 15 degrees are usually compensated for by peroneal muscle function, and therefore do not give rise to symptoms of a weak ankle.

Ankles that show a greater than 30-degree talar tilt give rise to symptoms of recurrent discostion of the ankle. This is the chronically weak ankle that gives way at the least provocation and is frequently a rather disabling condition. When this type of ankle gives rise to disabling symptoms, the only effective treatment

is operative stabilisation

The ankles that show persutent tilts between 15 and 20 degrees are not consistent in the significance of the tilt as related to chronic symptoms. Some of these tilts give rise to symptoms, others do not. It would appear that the presence or absence of symptoms depends upon the ability of the individual to compensate for the lack of ligament stability by persueal muscle function. Some people can accomplish this others cannot

There is a need for more definite information on the end results of severe ankle sprains and lateral ligament tears, particularly in relation to the type of treatment, duration of immobilization presence or absence of chronic symptoms and residual talar mobility as determined by reentgenographic examination under inversion stress following recovery from the acute symptoms

Conclusions

- 1 The diagnosis of tear of the lateral collateral ligament of the ankle joint is made by examination of the ankle with inversion stress under anesthesia. This condition must be considered in moderate and severe soft tissue ankle injuries.
- 2 The normal ankle under inversion stress will show less than a 10-degree talar tilt. Com plete tear of the lateral ligament and the lateral joint capsule will show a 30-degree or greater talar tilt.
- 3 Complete tear of the lateral ligament of the ankle probably requires prolonged immobilization in a plaster cast to insure complete healing
- 4 Undagnosed and untreated ligament tears may result in unstable ankles
- 5 Further information on end results is required before determining the most favorable treatment for complete tears

35 CHESTYUT STREET

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FRIEDLANDER'S BACILLUS MENINGITIS, TREATED IN PART WITH STREPTOMYCIN, WITH RECOVERY

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FRIEDLANDER'S bacillus meningitis is uncommon In 1943 Ransmeier and Major¹ surveyed the literature and found reports of 29 cases, to which they added one of their own. Of these 30 cases, only three survived. The one reported by Rothschild² in 1931 was the only reported recovery prior to the use of sulfonamides. Included in the group of 30 cases cited by Ransmeier and Major,¹ two cases² were cured following sulfapyridine therapy. Their article also mentions two cases⁵ c in which recovery followed treatment with sulfadiazine, although these latter two are not included in the group of 30 reviewed cases.

Since this survey was published, the author has found three more reports of such cases. In 1943 Mori⁷ reported a case in a 26-month-old infant in which recovery followed the use of sulfonamide (soluseptazine) therapy. King,⁸ in 1946, reported a case in a 6-month-old infant treated unsuccessfully with sulfadiazine. Autopsy of this case revealed meningitis, ileocolitis, and bronchopneu-

monia caused by the Friedländer bacillus

Later in 1946, Tartakoff, Grynbaum, and Le-Compte⁹ reported a case in a 49-year-old man This patient had a craniotomy for removal of a meningioma and subsequently developed Fried-länder bacillus meningitis. At first sulfadiazine and penicillin were employed without response Streptomyein was then administered intravenously and intracisternally. These authors noted a marked decrease in the viscidity of the spinal fluid following administration of streptomyein. The patient died and came to autopsy, where it was found that the cause of death was pulmonary embolism. There was nearly complete absence of microscopic evidence of meningitis.

To date, therefore, this author has found reports of 35 cases of Friedländer's bacillus meningitis in the literature, with recovery in 6 cases. I wish to report another case, treated in part with strepto-

mycin, in which recovery ensued

Case Reports

C R., a 65-year-old white woman, was admitted to the Kings County Hospital on August 7, 1945, because of fever and disorientation of eighteen hours duration For a year and a half prior to admission the patient had been troubled with severe pain in her left ear, accompanied by severe dizziness, for which she had attended the clinic of another hos-For a month prior to admission the patient had frequent attacks of buzzing in her left ear, followed by left hemicranial headaches Three days before admission the patient remained in bed because the headache was so severe At this time The day before she also developed a sore throat admission the patient became disoriented, developed projectile vomiting, and had a temperature of 105 F Stiffness of the neck also was noted the evening prior to admission. The history was otherwise

noncontributory

On admission the temperature was 101 8 F, pulse 96, respirations 24, and blood pressure was 140/90 There were no gross abnormalities of the head The pupils were round, regular, and equal, but appeared fixed in mid-dilatation The extraocular movements seemed to be normal. Funduscopic examination was normal The left eardrum appeared reddened, and there was loss of landmarks The neck was markedly rigid The lungs were clear to percussion and auscultation The heart was not enlarged, the sounds were of good quality, with normal sinus rhythm, and no murmurs were heard Examination of the abdomen was negative, and the extremities were in no way remarkable Neurologic examination revealed extreme nuchal rigidity and positive Brudzinski and Kernig signs bilaterally The Babinski sign was not present The abdominal reflexes were absent The deep tendon reflexes were hypoactive in all extremities

A lumbar puncture was performed on admission The spinal fluid was cloudy. The initial pressure was 450 mm water and final pressure 180 mm. On smear, there were many gram-negative encapsulated bacilli seen. There was a large increase in polymorphonuclear leukocytes. The impression on admission was meningitis, the cause to be determined. The possibility of a left-sided cerebral abscess was also considered. At this initial lumbar puncture 50,000 units of penicillin were injected intrathecally, and the patient was put on penicillin, 20,000 units every three hours intramuscularly. Sodium sulfadiazine was administered by the intravenous route, 25 Gm every six hours. The initial blood count revealed 21,000 white blood cells, with 84 per cent poly morphonuclears. There was 13 5 Gm hemoglobin. The admission urinalysis showed a three plus albumin but was otherwise.

negative

The patient's general condition was unchanged twenty-four hours later—At this time a report was received on the spinal fluid taken on admission and revealed total protein of 262 mg per cent, sugar less than 10 mg per cent, the smear showed many gram-negative encapsulated bacilli, and culture revealed type A Friedländer bacilli. At this time the dosage of penicillin was increased to 50,000 units every three hours intramuscularly. Another lumbar puncture was done and 20,000 units of penicillin injected intrathecally. Report of a blood culture taken on admission revealed the presence of staphylococcus aureus, which was considered a contaminant. Three other blood cultures taken during the course of the illness were sterile.

Two days after admission the patient's condition remained unchanged, and a blood transfusion was given as supportive therapy along with the other intravenous fluids. At this time it was becoming apparent that therapy with penicillin and sulfadiazine was ineffective in this case, and consideration was given to the use of streptomy cin. The patient's temperature varied between 99 2 and 103 2 F, the higher temperatures being attained in

the afternoon and evening. Since admission the patient had been unable to void spontaneously, which necessitated frequent catheterization nally a retention catheter was inserted. The thera peute regimen originally instituted with penicillin and sulfadiazine was continued while efforts were made to obtain a supply of streptomyein, which at that time was quite scarce and difficult to acquire The patient remained in a stuporous, comicomatose state, meaning frequently and at times becoming

quite restless. On the afternoon of August 10 1945 a supply of 10 000 000 units of streptomy cin hydrochloride was obtained from the Merck Company of Rahway New Jersey Because of the limited supply available, it was decided to give the patient 250,000 units every four hours intramuscularly although a much larger dose had been planned. Penicillin was discontinued, but sulfadiazine was maintained as before, 2.5 Gm every six hours. The first does of streptomy cin was administered at 4 1 M., August 10 1945 It had been noted on this day that the patient was beginning to show slight improvement in her general condition. She responded when her name was called and recognized members of her she began taking fluids and medication orally for the first time. All these signs of improvement were noted prior to the first dose of streptomycin.

The following morning a lumbar puncture was done and 250 000 units of streptomy cin in 10 cc of raline were instilled intrathecally. Within a few minutes the blood pressure fell to 100/40. No other signs or symptoms were observed. Threeeighths of a grain of ephedrine sulfate was given and the blood pressure soon rose to 140/80 noon the temperature had come down to 99.8 F The patient continued to maintain the improve-

ment first noted the previous day

The report on the spinal fluid obtained at this time revealed cloudy fluid, great increase in poly morphonucleurs, a few grant-negative intracellular bacilli, Friedlander bacilli present on culture after eventy-two hours, total protein 145 mg per cent, sugar 17 mg, per cent, sulfadiazine level 10 mg, per

The initial pressure was 200 mm. water, final pressure 110 mm. water with normal dynamics Pandy reaction was four plus. At 4 r u. that day the patient's temperature went up to 105 2 F and the sgain lapsed into come. Intravenous fluids and a second blood transfusion were administered as supportive therapy The resident otolaryngolonot examined the patient that evening He found a scar on the left tympanic membrane, but no evidence of middle ear abseces. Therapy with streptomyem and sulfadiazine was maintained. A blood count at this time revealed hemoglobin 12 Om., red blood cells 3 million white blood cells 10,800 with 05 per cent polymorphonuclears.

By the following morning the patient s tempera ture had fallen to 100 6 F and she again reguined consciousness and appeared to be quite rational A spinal tap was performed again (August 12) At this time only 100 000 units of streptomyon in 10 cc. of saline were administered intrathecally in view of the fall in blood pressure following the larger dose the previous day No untoward reaction was noted at this time. The laboratory report on this specimen revealed many pur cells, but no organisms were seen On the morning of August 13 1045 100 000 units of streptomyon again were injected intrathecally without reaction. The patients temperature at this time varied at about 102 F. The report on the spinal fluid specimen showed evidence that the infectious process was subsiding Culture and smear were negative The spinal fluid sugar however was less than 10 mg, per cent, and the total protein reached a peak of 443 mg, per cent. The sulfadianne level was 85 mg per cent. At this time there were no facilities for determining the concentration of streptomycin in the blood

At 8 rm on the evening of August 14 the pa tient had a shaking chill and sweated profusely 11011 had a shaning cum and sentence protused, By 8.AM the next morning her temperature had fallen to 99 F. The following day a large mass was felt in the lower abdomen. The patient was catheterised and 2500 cc of unne were removed. The analysis of this specimen rovealed no abnormalities At 4 A.M., August 18, the patient again had a severe chill with profuse perspira At this time it was noted that the nuchal rigidity was greatly decreased. A blood culture taken at this time was sterile. The blood level of sulfadiazine was 16 6 mg. per cent. The supply of streptomy ain had been exhausted on the provious day, August 17 but sulfadingine was con-tinued 2.5 Gm. every six hours the patient now taking the medication orally On the following day urinalysis revealed many sulfadiazine crystals present and there were 10 red blood cells per high power field Accordingly sulfadiazine was dis-continued The patients temperature varied be-tween 100 and 101 F

For the remainder of the hospital stay the chief difficulties of the patient were related to her urologic disorder She was unable to void spontaneous and even mobilization did not alleviate this trouble On August 31 she had gross hematuria and a day

later frank pyurla was noted.

A consultation with the urology service was obtained Cystoscopic findings revealed a mild trigonitis and slight contraction of the bladder neck. Tidal drainage was instituted and sulfadiazine therapy was again administered with a dosage of 1 Gm. every four hours with equal parts of sodium bicarbonate After four doses the patient's tem perature rose to 103 F Sulfadiazine was discontinued, as it was felt that the patient had become sensitive to the drug. Penicillin was then administered, 30 000 units every four hours for cleven doses Prostigmine therapy was given also Three days later the patient's unne cleared up almost en-tirely Following removal of the tidal drainage there was temporary incontinence of uring and feces. The patient also complained of frequent desire to vold and cramping sensations in her lower abdomen Culture of the urms on August 17 revealed the presence of staphylococcus aureus streptococcus vindans and B coli. A urine culture done on September 1 revealed B coli and streptococcus fecalis.

Inasmuch as the patient was completely ambula tory and afebrile at this time and because of her atrong desire to return home, she was discharged on September 7 1945, to the care of a urologist. Communication with the attending urologist revealed that only a mild cystitus was present, and this condition soon subsided. Intravenous uron raphy and cyatoscopy failed to reveal any other lesion. The patient was last seen approximately two months after her discharge from Kings County Hospital and appeared to be completely recovered

The accompanying Table I outlines the spinal fluid findings in this case and indicates the latra thecal therapy we employed. Streptomycin was also given intramuscularly in doses of 250 000 units every four hours from August 10 to August

17 1945 when our supply ran out.

TABLE 1.—Spinal Fluid Findings and Intrathecal Therapy

Date 8/7/45	Intrathecal Therapy Penicillin 50 000 µ	Turbidity Cloudy	Smear Gram negative bacilli, many	Culture Type A Friedländer	Total Protein Mg Per Cent 262	Quantitative Sugar Mg. Per Cent Less than 10	Sulfadiazine Level Mg Per Cent
8/8/45	Penicillin 20,000 µ		pus cells	bacilli No Re	eport		
8/10/45	Penicillin 20 000 μ	Cloudy	Gram negative bacilli many pus cells	Type A Friedländer bacilli (after 72 hours)	145	17	10
8/11/45	Streptomy cm 250 000 µ	Traumatic tap	Many red blood cells and pus cells	Sterile	173	Less than 10	8 8
8/12/45	Streptomycin 100 000 µ	Cloudy with purulent sediment	Many pus cells	Sterile		No Report	
8/13/45	Streptomycin 100 000 µ	Cloudy	Occasional gram-negative bacilli many pus cells	Sterile	443	Less than 10	8 5
8/14/45	Streptomy cin 100 000 µ		•	No Re	port		
8/15/45	Streptomy cm 100 000 µ	Slightly hazy	Some degener- ated cells	Sterile	327	49	8 7
8/16/45	Streptomy cin 100 000 µ	Traumatic tap	Many red blood cells	Sterile	253	44	11 5
8/17/45	Streptomy cm 100 000 µ	Turbid	Some red blood cells	Stenle	145	40	14 3

Discussion

The case herewith reported serves to emphasize certain of the salient features of Friedlander's bacillus meningitis, particularly as observed in the extensive survey of Ransmeier and Major 1 They noted the predisposition of the disease to occur in infants, elderly people, and those with debilitating They also found infections of the middle ear, mastoids, and sinuses in over half the adult Cultures of the spinal fluid from the initial lumbar puncture were positive in 15 of 17 cases Blood cultures were taken in 10 of the cases they Five of these were positive, and these patients died Of the 5 cases with negative cultures, two survived

Our patient was an elderly female, aged 65 had a history of left middle ear disease, presenting clinic evidence of this Culture of the spinal fluid from the initial lumbar puncture was positive for Friedländer bacilli, type A, as was the culture taken the following day Blood cultures were taken four times from this patient, all were negative, except the one taken on admission, which revealed a staphylococcus aureus, considered a contaminant.

It is difficult to assay the value of streptomycin therapy in this case As mentioned previously, several other cases have recovered with sulfonamides alone. The case of Tartakoff, Grynbaum, and LeCompte, like ours, was treated first with sulfadiazine and penicillin This was discontinued because of poor response, and for the last three days of life their patient received only streptomyon Inasmuch as the autopsy revealed nearly healed meningitis, we might postulate that had not pulmonary embolism ended his life, the patient would have recovered from the meningitis Our patient received sulfadiazine throughout the active phase of her meningitis, at first with penicillin, then with streptomycin, and alone for one day after our supply of streptomyon had been exhausted A very high

blood level of sulfadiazine, 166 mg per cent, was attained in this case The concentration of sulfadiazine in the spinal fluid reached a peak of 14.3 mg per cent, a very satisfactory therapeutic level It is possible that our patient might have recovered with sulfadiazine alone On the other hand, the findings of Tartakoff, Grynbaum, and LeCompte, as well as the evidence presented by Heilman,10 and Herrell and Nichols11 on the favorable effect of streptomycin on experimental and clinic infections caused by the Friedlander bacillus, lend support to the thesis that our case was benefited by the use of streptomycin

Conclusions

- A case of Friedländer's bacillus meningitis is reported.
- 2 Streptomycin was employed in part in the treatment of this case, in which recovery ensued
- The value of streptomy can and sulfonamide therapy in relation to this case and several others is discussed
- The author believes that in Friedländer's bacillus meningitis the treatment of choice is streptomycin, possibly in conjunction with the sulfonamides

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COMPLETE HEART BLOCK ALTERNATING WITH PARTIAL HEART BLOCK AND NORMAL SINUS RHYTHM IN CORONARY ARTERY DISEASE

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THE concurrence of complete heart block and coronary occlusion is not common and bears a grave prognosis. It is considered noteworthy to report this case of complete heart block which was discovered when the patient was experiencing anginal pain and transient episodes of distriness following a known episode of coronary occlusion with myocardial infarction. Complete heart block of the first compatible with long life but in the presence of serious coronary artery discusse a prolonged course of nine years from the initial episode of coronary occlusion and seven years from the first determination of complete heart block is remarkable.

Case Report

On January 0 1039 a white patient, aged 54, was even in his home for the first time with chief com plaints of precordial pain, shortness of breath, musea, and comiting after a hearty meal temperature was 09 and the pulse rate 100. The patient presented a history of coronary occlusion in April 1937 with electrocardiographic evidence of posterior myocardial infarction (Fig. 1) However after two days of bed rest and sodation he was able to retain food, felt well and insisted on returning to work On January 14, when he was in the office there were no complaints of shortness of breath or precordial discomfort. On physical examination no significant abnormalities were found. There was normal sums rhythm, no enlargement, the heart counts were of good quality, and no murmurs were leard. The pulse and ventricular rates were 80 and the blood pressure 110 systolic, 70 diastolic. The electrocardiogram revealed a PR interval of 0.28 second and myocardial changes consistent with coromary artery disease.

On subsequent visits the patient was asymptomatic until December 18, 1930, at which time he complained of postprandial precordial pain with shortness of breath On examination there were no objective changes and the pulse rate was 80 with normal sinus rhythm. During the next two weeks, fleeting attacks of dizziness were experienced, and the judient was seen again on December 27. The pulse rate was 33 and auricular contractions could be distinguished from vontricular. An electrocardiogram revealed the prosence of complete heart block (Fig. 2). The patient was started on ½ grain of ephedricular contractions and of polyments of the patient was started on ½ grain of ephedricular contract a day and advised to rest at home for

On January 15 101

On January 15 1040 the electrocardogram revaled a 2 1 auriculoventricular block (Fig. 3) and on April 5 normal sinus rhythm with prolonged PR interval and pulse rate of '4. The uphodrine was descentinced In June 1940 the patient complained of dixticess but no syncope and the pulse varied between 44 and 48 per minute during examination Epicodrine 1/1 grain three times a day was resumed.

Despite his alight diziness the patient continued well with normal sinus rhythm and no symptoms until October 3 1940 when the electrocardiogram again revealed complete heart block. The ephedrine was increased to ½ grain four times

a day, but the pulse and ventricular rates continued at 44 with the patient again experiencing distinces nausen and vomiting. On November 16 1940 the pulse rate wis 80 and the ophedrine was discontinued. On January 4, 1941 the blood pressure was 115 systolic 80 diastolic, pulse rate 44, and 1/s grain cephedrine four times a day was prescribed again.

tinued. On January 4, 1941 the blood pressure was 115 systolic 80 disable, pulse rate 44, and ¹/₂ grain ephedrice four times a day was prescribed again. During examination on May 7 1941 the pulse rate dropped from 80 to 44 and the patient became dizzy, flushed, and faint. On May 23, an electrocardiogram showed a 21 auricultoventricular block, ophedrine was renewed, but the dissiness continued and the pulse rate varied from 30 to 46. The patient continued in this way with cocasional episodes of dizzinosa and in June 1942, another electrocardiogram revealed complete heart block still present. This condition remained permanent, thereafter, as evidenced by electrocardiographic studies, the last being taken on July 23 1946 (Fig. 4.)

The patient's course was uneventful and apparently asymptomatic from this last date until word was received of his sudden death while walking out

doors in December 1946

Discussion

Auriculoventricular block in older individuals as a scrious disorder with a grave prognosis for it is usually indicative of progressive narrowing of the coronary vessels with diminution of blood supply to

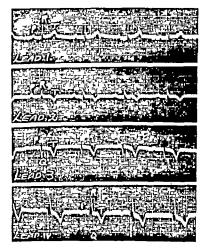


Fig 1. (April 17 1937) Changes of acute coronary artery occlusion involving the posterior aspect of the heart. P R interval 0.22 second

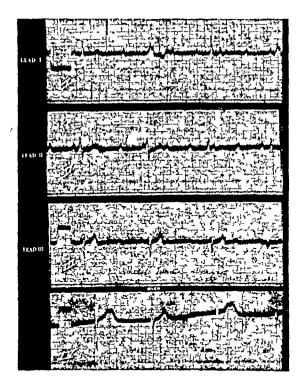


Fig 2 (December 27, 1939) Complete heart block with variable ventricular response

the junctional tissues 12 The fluctuating character of the conduction changes is probably due to the variable supply of blood to these tissues, since collateral circulation may bring recovery to the ischemia of the auriculoventricular node and bundle 3 4 Also, the resolution of inflammatory changes and/or edema in the region of the junctional tissues may account for the transient occurrences of complete and partial heart block and normal sinus rhythm With the progressive narrowing of the coronary vessels, the block may become permanent and, as is not usually true with complete heart block itself, the eventual outlook becomes more serious

The chief blood supply to the auriculoventricular conduction system is direct from the right coronary artery through the ramus septi fibrosi which supplies the superior portion of the interventricular system and sends a branch to the auriculoventricular node, 5 a small percentage is supplied by the circumflex branch of the left coronary vessel

In this patient, the original episode of coronary occlusion was followed by infarction of the posterior ventricular wall which usually is supplied by the posterior descending branch of the right coronary artery. The entire course which followed can be attributed to further embarrassment of the coronary circulation with eventual permanent damage and finally exitus of the patient

It is noteworthy that with these changes in auriculoventricular conduction occurring in a patient who had had a definite coronary occlusion with infarction, the length of survival was slightly

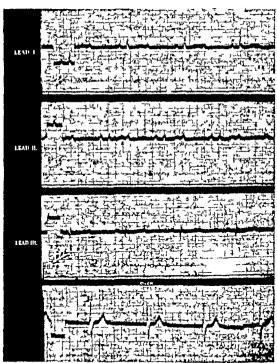


Fig 3 (January 15, 1940) 2 1 partial heart

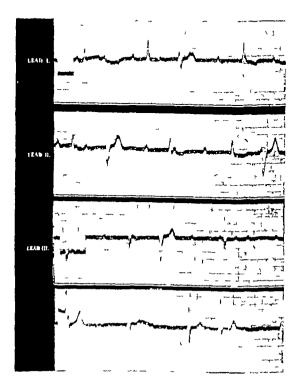


Fig 4. (July 23, 1946) Complete heart block with variable ventricular response

over nine years from the first episode, and seven years from the discovery of complete although transient heart block

Ephedrine was found to be most beneficial in alleviating the episodes of dizziness

Summary

A case of complete heart block, alternating with partial heart block and normal sinus rhythm, is reported in a patient with senous coronary artery disease with a survival of nine years from the initial coronary occlusion and soven years from the discovery of complete heart block.

References

1 White Paul D: Heart Disease, New York Mamilian Compuny, 1944
2. Comeau, Wilford J: Am. J M Sc. 194: 43 (July)
13 knauer John G Ann. Int. Med. 8. 1475 (May)
1935.
4 Ball David Am. Heart J St. 227 (Feb.) 1933.
5 Schwartz Sidney P Am. Heart J 11 554 (May)

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ILLINOIS SETS UP \$100 000 JOINT FUND TO TRAIN MORE COUNTRY DOCTORS

Full details of a joint \$100,000 plan for financing medical education for farm boys in Illinois to increase the supply of doctors in rural areas were made public recently by the Illinois State Medical Society and the Illinois Agricultumi Association cosponers of the plan The plan is part of a broad program for expanding health care in rural Illinois by establishing regional health councils, recruiting doctors and nurses, and building hospitals.

The medical training plan is based on a fund to

be established by a contribution of \$50,000 cach by the two organizations. The \$100,000 total will then serve as a revolving loan bank from which loans will be made to accepted modical students at the rate of \$1 000 a year to a maximum of \$5 000 perstudent

The program is believed to be the first instance of such cooperation between farm and medical groups to solve their own problems with their own funds

Its importance is emphasized by studies which show that replacement of doctors in downstate fullinois is not occurring that in another ten years more than half the doctors in rural Illinois will be superannuated and that the supply of doctors is directly proportional to the per capita income of predominantly rural countries. The program is designed to meet those specific findings.

ANNOUNCEMENT

To the County Clerks of New York State Gentlemen

This is to notify you that the Board of Regents at a meeting held September 10 1047

COTED, That the determination of the Medical Committee on Grievances in the matter of the application for the revocation of the medical lecence heretofore granted to Benjamin R. Tuppersen York City to accepted and sustained that in compliance with the recommendation of said committee the indorsement of the medical distonation of Physicians and Surgeons of New York City such indorsement made on September 3 1835 constituting his authority to practice medicine in this State be revoked annulled and can

celed and that his registration or registrations as a physician wherever they may appear be ordered annulled and canceled of record and that the Commissioner of Education be empowered and directed to execute for and on behalf of the Board of Regents all orders necessary to accept the determination of said Committee on Grievances and to carry out the terms of this vote.

Dr Tupper was registered for 1947-1948 from 205 West 85th Street, New York City The order of revocation was served on Dr Tupper on October 28 1947

(Signed)
JACOB L. LOCHNER, JR., M D., Secretary
A Y State Board of Medical Examiners
November 3 1947

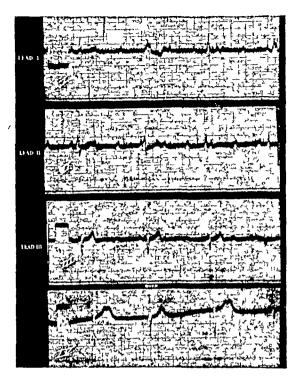


Fig 2 (December 27, 1939) Complete heart block with variable ventricular response

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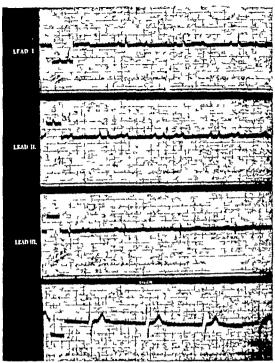


Fig 3 (January 15, 1940) 2 1 partial heart block

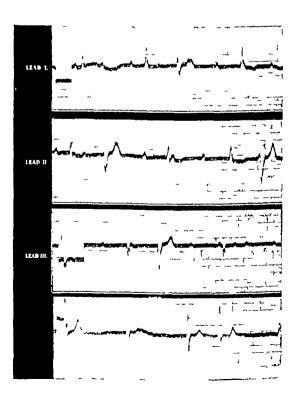


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References

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 2 Comean Wilford J Am. J M Sc 194: 43 (July) 1937
- 8 Knauer John G: Ann. Int. Med. 8: 1475 (May)
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(Signed)

JACOB L. LOCHVEB, JR. M D., Secretary V Y. State Board of Medical Examinets November 3, 1947

DEVELOPMENTAL ARREST BY INFANTILE TOXOPLASMOSIS

I NEWTON KUGELMASS, M D, New York City

A FOUR-YEAR-OLD white boy, Stephen Arnold H., was brought for examination because of arrested growth and development. He had made no significant gains in height and weight for over two years, never attempted to speak, and had difficulty in seeing even objects brought close to his eyes. The boy ran about purposelessly during the day and tossed about restlessly during the night. He was a first-born, full-term infant, normal delivery. His developmental course was satisfactory from birth, having held his head up at four months, sat up at seven months. His psychomotor responses during infancy indicated normal mental progress.

At about sixteen months of age the baby was taken to a farmhouse in the Catskills for the summer. He continued to thrive until the end of that season Then he suddenly became limp, disoriented, vomited, and developed diarrhea and moderate fever for five days. The condition was treated as an "acute gastroenteritis" which marked the onset of subsequent developmental difficulties. The mother voluntarily elicited the fact that her baby was very fond of a sick puppy with whom he played during most

of his stay on the farm

Some of the manifestations of the acute episode persisted throughout the fall at home in the city. The baby continued to vomit his feedings, pass loose stools filled with mucus, and ran a low-grade fever. He was disinterested in his surroundings, could not be induced to play for any length of time, and became increasingly restless and irritable. All forms of dietary and medical treatment were without avail. The persistent illness was diagnosed as chronic intestinal indigestion, celiac syndrome, intestinal worms, birth injury, and mental deficiency, respectively, by various physicians.

Physical examination in October, 1946, revealed a puny boy of four years, weight 28³/4 pounds, height 3 feet, body build linear His face was pinched, mobile, and tense, his crossed eyes roved restlessly in all directions, his mouth frequently washeld open, his head was retracted with a fixed smile imprinted upon the face The skin was pale, sallow, dry, and devoid of subcutaneous fat He seemed unadjusted to the eye glasses prescribed a year previously for poor

vision and strabismus

The fundus of the right eye revealed an astounding picture. The disk appeared raised and was surrounded by reddish-brown, sharply defined margins, streaks of pigment two to three times the disk diameter. These large, concave, slightly elevated patches of chorioretimitis were located in the lower temporal region of the right fundus and the lower nasal portion of the left. The vitreous was clear and the retina free from edema or hemorrhage. The right pupil was slightly smaller than the left, but both reacted to light. There was a vertical nystagmus in both eyes looking upward, a horizontal nystagmus looking to the left, and a lateral disturbance of movement in the right eye. Other extra-ocular movements were normal

Muscle tone strength and speed of contraction were normal with exception of the right lower extremity which was somewhat spastic. The child responded to pain sensation throughout the body. The corneal, epigastric, hypogastric, patellar, and Achilles reflexes were normal bilaterally I Q (Kuhlmann) was 60 Roentgenographic examination of the skull was normal. The sella was very small with a tendency to bridge. There were small flecks of 1 mm in length observed in the basalganglia. This intracerebral calcification was visualized by stereoroentgenogram of the head. Blood examination was strongly positive of toxoplasma neutralizing antibodies. There was a hypochromic, microcytic anemia and leukopenia but no cosmophilia.

The cue to the diagnosis was the bizarre appearance of the fundus so characteristic of to oplasmic encephalomyelitis. Routine examination of the fundus of all children has its reward in the prompt recognition of this rare disease. The chorioretinitis, macrophthalmos, optic atrophy, spasticity of the extremities, aphasia, and arrested development are characteristic manifestations of the disease. The history of close contact with a sick animal points to the onset of this parasitic infection which leads to mental and developmental retrogression. Positive antibody reaction and presentation of intracerebral calcification are confirmatory of toxoplasmosis.

The disease has a predilection for the central nervous system but the infection is generalized and involves many organs. The relative effects of toxoplasmosis on the central nervous system is magnified in the later stages by the permanent character of the residual lesions. This maintains because of the inability of nerve cells to regenerate, while lesions in other organs tend to heal with little or no residue. The present case reveals the effects of a generalized invasion of tissue cells with resultant impairment of function of the brain, central nervous system, musculature, skin, and blood from clinical evidence

Treatment consisted of a course of sulfapyridine maintaining a blood level of 5–10 mg per cent. Its effectiveness in experimental toxoplasmosis was a possible indication in this subacute parasitic infection. The sulfa was supplemented by parenteral folic acid for the anemia and prostigmin for the spasticity. One million units of penicillin in oil and wax was injected daily for five days when leukemia developed. The boy's appetite improved, the low-grade fever cleared, and the spasticity decreased. His weight increased progressively and the height even more strikingly.

The boy has become interested in his surroundings and is responding more rationally. He is now making normal vowel sounds and attempting the consonants. But the improvement is more apparent than real in comparison with two years of retrogression.

^{*} Acknowledgment is due to E R. Squibb and Sons for providing penicillin to Lederle Laboratories for folio acid and to Hoffmann La Roche, Inc for prostigmine

MEDICAL NEWS

NYU College of Medicine Inaugurates Laboratory of Toxicology

THE Laboratory of Research Toxicology initial unit of the recently inaugurated Institute of Industrial Medicine of the New York University Bellayue Medical Center has been established under

the direction of Dr Norton Nelson.

Dr Nelson, former research associate of the Children's Hospital Research Foundation in Cin cinnati, and assistant professor of biological chemistry at the University of Cincinnati, has been named associate professor of Industrial Medicine.

Graduate blochemist of the University of Cin-cinnati, and later active in research in blochemistry, Dr Nelson took a leading role in that field during World War II at Fort Knov Kentucky where he

was a member of the staff of the Armored Medical Research Laboratory He was discharged as a Lieutenant Colonel of the Sanitary Corps.

The establishment of the laboratory is the cul-mination of plans announced last June, when the Institute was inaugurated, under the leadership of Dr A. A. Lonza, as a training and research unit, dedicated to the problems of industrial medicine At that time it was announced that the Institute would feature the specialized training of experts in industrial medicine through a graduate program, leading to appropriate recognition and research not only in tovicology but industrial physiology and psychology tropical medicine and social medicine.

Set Health Survey for New York City

THE first comprehensive health survey of New York City in twenty years as a basis for the de-Lyork City in twenty years as a besis for the development of a health plan in which all health agencies will be united to cooperate, has been initiated as a joint undertaking of the Health Council of Greater New York and the Public Health Relations Committee of the New York Academy of Medicine, it was announced recently by Dr I Og den Woodruff, president of the Health Council of Greater New York, which is financing the project. The Health Council consists of representatives of 85 health and allied agencies of New York City—Endorsement of the survey came from Dr Harry

Endorsement of the survey came from Dr Harry 8 Mustard, Commissioner of Health who said, The Health Department strongly endorses the undertaking and is prepared to cooperate in every

The survey will be directed by Dr E. H. L. Corwin executive secretary of the Public Health Rola tions Committee of the Academy of Medicine.

The purpose of the survey is to assemble data for use by the long range program committee of the Health Council. Co-chairmen of the program committee are Dr. Howard Reld Craig and Balley, B. Burritt, with Dr. Thomas D. Dublin as associate chairman. Dr. Craig is director of the New York Academy of Medicine, Mr. Burritt is director of the New York Academy of Medicine, Mr. Burritt is director of the New York. National Health Council and Dr Dublin is professor of preventive medicine of the Long Island College of Medicine.

State Charities Approach New Era

THAT the State Charities Aid Association is on the threshold of a new era of service in fields of health and welfare was proclaimed by Dr George Bachr president of the New York Academy of Medicine and member of the Association s Board of Managers at its seventy fifth anniversary meeting December 9 in New York City

The need for an association to express the will of the people of our State and to assist them to under stand and participate effectively in local health and wellare programs is greater today than ever be-

Ging the part played by the Association in helping to establish the State's modern health de-

partment, which has been a model for thirty five years to all the other States of this country! Dr Bachr called attention to recent implementation of the Public Health Laws which now provide grantsin-aid for establishment of properly organized health units This gives the Association a glorious oppor-tunity to stimulate and aid people in all parts of the State to improve administration of public health in their local communities he said.

Approval of the Association s integrated approach to health, mental hygiene, and welfare problems and its increasing emphasis upon prevention recurred in addresses of speakers which included Dr Herman E. Hilleboe, New York State Health Commissioner

To Build Medical Center

THE United States Atomic Energy Commission announced recently that it would spend \$615 000 to build and equip a six-story medical and biological training and research conter on the campus of the University of Rochester at Rochester New York.

The project was recommended by the commissions

sion a committee on biology and modicine. In urg ing the center this committee stated that the com

bination of a large medical school enrollment and

the consequent lack of adequate training and teach-ing facilities was a major obstacle to the program. At the center physicians will receive a postgrad unte training in the treatment of radiation sickness, training in the use of radio-isotopes for tracer studies and therapy and instruction in such topics as phar macology and toxicology of radioactive materials,

Doctors Sign Euthanasia Plea

A PETITION for the legalization of euthanasia, signed by more than 1,000 physicians throughout the state, has been sent to members of the State Legislature, it has been announced by the Euthanasia Society of America and the Committee of 1,776 Physicians for Legalization of Voluntary Euthanasia in New York State

The petition suggests that the State law be amended to "permit voluntary cuthanasia for incurable sufferers, when authorized by a court of record,

upon receipt of a signed and attested petition from the sufferer and after investigation of the case by a medical committee designated by the court "

At present, the petition charged, "many incurable sufferers, facing months of agony, attempt crude, violent means of suicide, while in other cases distraught relatives of hopeless incurables who plead for merciful release secretly put them out of their misery and thereby render themselves liable to prosecution as murderers"

MEETINGS

Past

New York State Association of Public Health Laboratories

Dr Gustav H Klinck, Jr, director of the Cluett Pathological Laboratory of Samaritan Hospital, Troy, gave a report on improved laboratory methods of cancer diagnosis at the midvear meeting of the New York State Association of Public Health Laboratories in Albany on November 7

Others reporting on new methods were Dr George N Papamcolaou, Cornell University Medical Col-lege, and Dr John C McClintock, Albany Medical College Principal speaker at the meeting was Dr Geoffrey Edsall, of the Massachusetts Department of Public Health, who described his state's transfusion program, which provides blood transfusions for the entire population of the state irrespective of financial or geographic hardships

New York Council of Surgeons

Dr Ludwik Gross, chief of the cancer research division, Veterans Administration Hospital, spoke on "Current Trends in Cancer Research" at the meeting sponsored by the New York Council of Surgeons, December 9, at the Parkchester General Hospital, New York City

On December 16, Dr Wilbert Sachs, assistant professor of dermatology at Cornell University Medical School, gave a lecture on cancer of the skın

Saranac Lake Medical Society

"Gastroenterological Aspects of Psychosomatic Medicine" were discussed by Dr Richard I Kilstein, acting chief in gastroenterology at Beth David Hospital, New York City, at the meeting of the Saranac Lake Medical Society held December 10 at the Saranac Laboratory

On December 17, Dr Thomas Hale Ham, assistant professor of medicine, Harvard University Medical School, spoke on "Hemoglobinuria Resulting from Severe Thermal Burns"

Memorial Hospital of Queens

At the clinical conference held December 16 at the Memorial Hospital of Queens, Dr J Hamilton Crawford, director of medicine, Long Island College Hospital, read a paper on "The Treatment of Heart Failure," and a case presentation was made by Dr Theodore Cohn, who spoke on "Anticoagulant Therapy in Clinical Medicine," and Dr I I Greenblatt, who discussed "Biochemical Aspects of Heparin and Dicoumerol"

Eastern New York Eye, Ear, Nose and Throat Association

Dr Donavan McCune, New York City, spoke on 'The Relations Between Ophthalmo-Otolarvngology and Pediatrics" at the meeting of the Eastern New York Eye, Ear, Nose and Throat Association on January 8 in Schenectady

Geneva Academy of Medicine

Postgraduate instruction arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York was held January 15 for the Geneva Academy of Medicine at Geneva Dr Foster Kennedy, professor of clinical medicine at Cornell University Medical College, spoke on "Nervous Conditions Associated with Al-

Future

American Laryngological, Rhinological and Otological Society

The Eastern Section meeting of the American Laryngological, Rhinological and Otological Society will be held January 16 at the Waldorf-Astoria Hotel, New York City, with sessions beginning at

Speakers and their topics include Dr James S Greene, New York City, "Vocal Sequelae to Oral and Nasal Conditions", Dr John A Murtagh, Hanover, New Hampshire, "The Sensitivity of Individual Fibers of the Recurrent Laryngeal Nerve",

Dr Austin T Smith, Philadelphia, Pennsylvania "Orbital Complications Resulting from Lesions of the Sinuses'

Also Dr Edmund P Fowler, Sr, New York City, "The Emotional Factor in Tinnitus Aurium", Dr Will C Spain, New York City, "Importance of Allergy in Ear, Nose and Throat Conditions", Dr Ralph Tompsett, New York City, "Relation of Dosage to Streptomy cin Tovicity," and Drs Edward H Campbell and Douglas McFarlan, Philadelphia, Pennsylvania "Test Findings Before and After the Labvrinth Fenestration Operation" After the Labyrinth Fenestration Operation"

New York Academy of Medicine

A symposium on "The Diagnosis of Viral and Ruckettaial Infections" will be held at the New York Academy of Medicine under the auspices of the Section on Microbiology on January 20 and 30

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The program will include influenza, Dr Georgo
k. Hirst numps, Dr Werner Henle paittacesislymphogranuloma group of viruses (including tracoma and inclusion blennorrhen) Dr Geoffrey W.
Rake, primary atypical pneumonia Dr Frank L.
Horsiall, Jr , neurotropie virus infections (including
the viral encephaltitides, lymphocytic choriomening
is and poliomyelitis) Dr Jord Casals, herpes virus
Dr T F McNair Scott, rabies, Dr Harald John
son, deague, Dr R. Walter Schlesinger infectious
mononucleosis, Dr John R. Paul opidemic munno,
and serub typhus as well as Q fover Dr Joseph L.
Smadel, Rocky Mountain spotted fever and rickettital pox, Dr Ileraid P Cox, and infectious hepa
ilid, Dr W Paul Havons, Jr

East New York Medical Society

A meeting of the East New York Medical Society will be hold on February 2 at the Kings County Medical Society Building, Brooklyn. Dr. Ira T. Natharson, assistant professor of surgery. Harvard University and director of the Harvard University Cancer Commission, Massachusetts General Hospital, will speak on Results of the Treatment of Cancer. The program will began at 9 r.m.

Geneva Academy of Medicane

Dr Wesley T Pommerenke associate professor of obstetries and gynecology at the University of Rochester School of Medicine and Dentistry will seek on "Dysmenorrhea a a moeiting of the Genera Academy of Medicine to be held February 19 at the Senera Hotel Geneva. The program of

postgraduate instruction was arranged by the Medical Society of the State of New York with the cooperation of the New York State Department of Health

On March 18 a second program will be presented for the Geneva Academy Dr Joseph E. J King, director of neurosurgery at Bellevue and Leuoz Hill hospitals, and instructor in surgery at Cornell Um versity Medical College will speak on Head In juries and Brain Absects.

Both programs will begin at 8 30 i M

Association for the Study of Internal Secretions

The Association for the Study of Internal Secretions announces a postgraduate assembly in endernology to be held in Los Angeles California from February 23 to 28 The faculty is to be composed of outstanding students of endocrinology in the United States and Canada.

Applications may be sent to the chairman of the Committee on Postgraduate Instruction Dr E. Rost Shelton 921 Westwood Boulevard, Los Angules 24 California.

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American College of Chest Physicians

A postgraduate course in diseases of the chest is to be sponsored by the Penus Ivania Chapter of the American College of Chest Physicians, during the week of March 15 to 20 at the Warwick Hotel Philadelphia, Penusylvania Emphasis in the course will be placed on the newer

Emphasis in the course will be placed on the newer developments in all aspects of diagnosis and treat ment of diseases of the chest. Limited to 30 physicians, the course has a tuttion fee of \$50 for members and \$00 for non-members.

Further information may be secured at the office of the American College of Chest Physicians 500 North Dearborn Street Chicago 10 Illinois.

PERSONALITIES

Honored

Dr. Maurice I Lew! native of Albany and now president of the First Institute of Podiatry at Long resident of the First Institute of Podiary at a re-island University who was guest of honor at a re-eption at the Hotel Pennsylvania, Now York City on December 2 on his ninetieth birthday, a graduate of Albany Medical College former prosident of the Albany County Medical Society Dr. Lewi has headed the Lastitude of the County Medical Society Dr. Lewi has headed the Institute since 1913 and is still active in teaching Dr John R MacElro, a practicing physician at Jonewille for 53 years and Saratoga Constitution of the Constitu County health officer for 35 years, who was honored by approximately 400 residents of the area, which inrades Jonesville Round Lake Maltaville, Hall Moca, Cluton Park, Grooms Cornera, Vischers Ferry Burnt Hills, Ballston Lake and Schenectady who gathered to may tribute to their family docat ceremonies on December 4 at the Jonesville liethodist Church Past president of the State Health Officers Association and the Saratoga County listical Society be was graduated from the Albany Medical College in 1804 Dr Albert Salisbury Hyman, New York who was awarded the Equare Clubber of the lear Gold Key of the Master Mason Paymetan for his outstanding work in Masonry and or in he did medicine, at the 20th annual convention of the Association of Physicians Square Clubs of American Square Club America, December 14 in New York City

Elected

Dr John J Quinlan Troy to his second turn as president of the Renssoler County Boord of Health Dr Bonjamin Grossman, Queens, as grand president of the Association of Physicians Square Clubs of America, for 1948 succeeding Dr M Milton Eckert, the Bronx. Dr Max Helfand, elected president of the Physicians Square Club of New York Dr Henry Rubinstein, president of the Physicians Square Club of Brooklyn Dr Henry G Glazer president of the Physicians Square Club of the Bronx. Dr Maxwell Liebzrman, president of the Physicians Square Club of the Physicians Square S

Speakers

Dr Thomas B Bumbalo Buffalo pediatrician on Protection of Children Against Acute Communicable Diseases at a meeting of the Century Club Niagara Falls, on November 13 Dr Louis Davisson and Dr Jere Lord, Jr New York, at the monthly meeting of the Mount Vernon Medleal Sciency on November 20 Dr Ismes E. Fish Ellis Hospital Schenestady on the status of the general practitioner at a meeting of the Union College Providence Society Dr Arthur Alexander Knapp, New York City on Blinding Diseases of the World —Prevention and Treatment, at the Third Pan-American Ophthalmological Congress in Havana,

Cuba, from January 4 to 10 Dr Harry S Mustard New York City Commissioner of Health, on "Nutrition and Public Health," at the symposium sponsored by the Columbia University School of Public Health on December 11 Dr Peter B Riley, Amsterdam, on child psychology at a meeting of the Daughters of Jacob, Amsterdam Dr Samuel Sanes, chairman of the Cancer Control Committee, Eric County Medical Society, on detection and control of cancer, at a meeting of the Madame Sklodowski-Curie Society, Branch 334, Polish Women's Alliance, Buffalo, on November 18 in commemoration of Madame Curie's birthday

New Offices

Dr Harry F Benjamin, who served in Army Medical Corps and on medical staff of Saratoga Veterans Hospital, general practice in Schenectady Dr Sawyer A Glidden, former medical officer in US Army, general practice in Holley Dr Soltan Mann, general practice in Jeffersonville Dr Paul Rekers, Rochester, general practice in Wal-

worth.

Dr Thomas L Rider, practice of pediatrics in Albany Dr Philip E Rossiter, general practice and genatrics, in Avon, served in US Army Medical Corps as major

COUNTY NEWS

Allegany County

Dr Raymond O Hitchcock, of Alfred, was elected president of the Allegany County Medical Society at the annual meeting in Belmont on November 13 Other officers are Dr J Paul Rems, Belmont, vice-president, Dr Hazen G Chamberlain, Cuba, secretary, Dr Loren E Bly, Cuba, treasurer, and Dr Irwin Felsen, Wellsville, delegate to the State convention

Possible establishment of a cancer clinic in the county was discussed, but no action was taken

Broome County

A three-point attack on rheumatic fever heart disease has been opened by the Broome County Tuberculosis and Public Health Association in conjunction with the Broome County Medical Society A central registry for reporting all cases of rheumatic fever in the county has been established as the first step in the program

The heart program has three aims (1) to discover all rheumatic fever cases by means of the central registry, the first of its kind in the State, (2) to obtain early medical care for persons with symptoms of the disease, (C) to facilitate prevalence studies of rheumatic fever among children and

young adults in the county

Chemung County

Election of officers for 1948 and reports of committees featured the annual meeting of the Chemung County Medical Society, held on December 10 at the Arnot-Ogden Hospital Library, Elmira, with Dr D J Tillou presiding

Officers elected for 1948 are Dr A C Glover, president, Dr G T Connelly, vice-president, Dr H A. Burch, secretary, Dr Earle G Ridall, treasurer, Dr W T Boland, delegate, and Dr Tillou, alternate

Dr J F Lynch, charman of the Cancer Committee, gave a report on the recommendations of the Committee, which included the institution of two cancer detection centers, one in each hospital. The report was unanimously accepted by the members present

Dr L Dichter and Dr Arthur D Smith were elected to membership in the County Society

A letter from Corporation Counsel George Winner was read, requesting doctors not to advise their patients that the city is responsible for lunacy examinations, as the city is entitled to reimbursement wherever possible

Clinton County

Postgraduate instruction, arranged by the Council Committee on Public Health and Education of the State Society for the Clinton County Medical Society will be given on three Thursday nights at the Champlain Valley Hospital Nurses Home, Plattsburg

The program, with speakers and their subjects, includes January 15—"The Treatment of Persistent or Recurrent Dyspnea," Dr Frederick T Schnatz, assistant professor of medicine, University of Buffalo School of Medicine, February 19—"The Treatment of Low Back Pain," Dr George H Marcy, instructor in orthopedic surgery, University of Buffalo School of Medicine, and March 18—"The Treatment of Epigastric Distress Following Meals," Dr A. H Aaron, professor of clinical medicine, University of Buffalo School of Medicine

Dutchess County

Dr Frederick S Wetherell, professor of surgery at Syracuse University, School of Medicine, spoke on "The Relations of the Sympathetic Norvous System to General Medical Problems," at the meeting of the Dutchess County Medical Society on November 12 at the Hudson River State Hospital, Poughkeepsie

Dutchess County's Board of Supervisors was reported to be planning to accept the recommendation of the Dutchess County Medical Society to add a second assistant medical examiner. The proposed 1948 budget included an appropriation for this purpose

Last spring the Medical Society proposed that the board make provision for a second assistant examiner. In order to accomplish this, the Board of Supervisors will have to petition the State Legislature to amend the special Dutchess County Medical Examiner Act, which now provides for a medical examiner and one assistant.

Fulton County

Dr W L Gorham of Albany was guest speaker at the dinner meeting of the Fulton County Medical Society held November 19 in Gloversville His topic was 'Diet and Heart Disease"

The members of the county group voted during the buryings meeting to eccept the the Fulton

The members of the county group voted during the business meeting to cooperate with the Fulton County Chapter of the American Society for the Control of Cancer in establishing an information center which will be devoted to providing more in

formation to the general public on cancer Three physicians, Drs. Robert C Warner, J Sponnoble, and Richard Howard, were elected as new members of the Society

Jefferson County

Dr L. Otis Fox, Brownville, was elected president of the Jefferson County Medical Society at the an nual meeting held November 13 in Watertown succeeding Dr Wendell D George

Other officers chosen are Dr Walter Fox Smith, vice-president Dr Charles A Prudhon, secretary, Dr Lawrence E. Henderson, treasurer, Dr Prud hon, delegate, and Dr E. E. Babcock, Adams Cen-ter, alternate. Dr Harold C Livingston Dexter, and Drs. Charles W Robertson and Robert B Burch, Alexandria Bay were elected to membership

Appointed editor-in-chief of the Northern New lork Medical Journal, the official publication of the Jefferson County Medical Society which is published annually was Dr James C Harberson He succeeds Dr J R. Pawling

Nassau County

A series of postgraduate matruction lectures, to be held on Tuesday afternoons at 4 P M. at the Nassau Hospital Auditorium, Minoola, has been arranged for the Nassau County Medical Society by the Council Committee on Public Health and Education of the State Society

Dates, lecturers and topics are

January 20-Dr Lowis Stovenson, professor of cinical medicine and associate professor of pathology, Cornell University Medical College, New York, Clinical Aspects of Encophalitis and Pollomyelitis."

January 27—Dr Harry Most, associate professor of preventive medicine, New York University Col-

se poventivo medicino, New York University Orlego of Medicine, "Tropical Disease, Civilian Implications of Military Experience.

February 3—Dr. Edward F. Hartung, chief of division of arthritis, New York Poet-Graduate Medical School and Hospital, Diagnosis and Treat met of Lee Buck Dall Care. ment of Low Back Pain from the General Practitioner's Point of View

February 10-Dr E. Charles Kunkle instructor in medicine, Cornell University Medical College, "Headache Mechanisms

This instruction is provided by the State Society with the cooperation of the New York State Department of Health

New York County

The New York County Medical Society representing 6 500 physicians, announced that it had sent a letter to the Board of Estimate urging that body to approve a change in the soning regulations that would permit physicians and dentists to maintain offices in residential districts although they do not live in the same premises.

Dr Harold B Davidson, president, said existing restrictions put an "almost intolerable burden on medical veterans who have returned from military service and are seeking office space to resume prac-tice. Sovere hardship would be imposed on the Public if restrictive zoning regulations were to re-quire physicians to move from their present loca-tions, he stated.

Ottego County

"Recent Advances in Thorapy' was the topic of a keture given by Dr Richard H Lyons professor of medicine, Syracuse University College of Medicine at the meeting of the Otsego County Medical Society held December 17 in Cooperstown

The lecture was postgraduate instruction arranged by the State Society in cooperation with the State Department of Health

Putnam County

Opposing any system of compulsory health insurance members of the Putnam County Medical Society, at their meeting on November 5 in Carmel adopted the following resolution

WHEREAS The members of the Putnam County Medical Society believe that the practice of medicine shall remain a free and independent profession

and,
"Whineas, Experience in other countries indicates
"Whineas, Experience in other countries indicates lowers the scientific and professional standards of the physicians and herewith the quality of medical sorvice, encourages malingering, and becomes a heavy burden on society be it

"Resolved We the members of the Putnam County Medical Society are opposed to any system of compulsory health insurance. We are in favor of greater support to voluntary health insurance plans which have been approved by the medical

profession.

Queens County

Dr Elaine Ralli, attending physician Bellevue and Goldwater Memorial hospitals, and associate physician in medicane, New York University Hospital, spoke on 'The Modern Management of Curhosis' at a meeting of the Queens County Medical Society held December 12 at the headquarters in Forest Hills.

Dr Anoch H Lewert, Jamaica, chairman of the orthopedic section of the Queens County Medical Society, addressed members of the Queens Cerebral Palsy Society at their meeting on November 17 in Elmhurst.

Rensselaer County

Dr Herman E. Hilleboe, commissioner of health for New York State, spoke on 'The Challenge of Public Health in Europe and in the United States" at the first annual dinner of the Rensselser County Health Department, held November 13 in Troy

More than 200 members of the Health Department, the County Health Board, the County Medical Society, the Pawling Sanitarium staff and county officials attended the dinner Dr John J Quinlan president of the board, introduced the guests.

Richmond County

A series of postgraduate instruction lectures, ar ranged for the Richmond County Medical Society by the Council Committee on Public Health and Education of the State Society is being held during January on Friday alternoons in the auditorium of the United States Marine Hospital Stapleton, Staten Island

Speakers and their subjects are January 9-Dr Russell L. Ceell, professor of clinical medicine, Cornell University Medical Col-lege, New York, Treatment of Chronic Arthritis.

lege, New York, Treatment of Chronic Arthritis.
January 16—Dr Carl T Javer, assistant professor of obstetrics and gynecology Cornell University Medical College, Clinical and Obstetric Significance of the Rh Factor

January 23-Dr Emanuel Muskathlit, associate

clinical professor of dermatology and syphilology, New York University College of Medicine, "Ring-worm of the Scalp — Its Diagnosis and Treatment" January 30—Dr Thomas H McGavack, professor of clinical medicine, New York Medical College,

Flower and Fifth Avenue Hospitals, "The Treatment of Hyperthyroidism"

Rockland County

Dr George G Stone, Suffern, was elected president of the Rockland County Medical Society at the annual meeting held on December 3 at the Summit Park Sanatorum

Other officers chosen were Dr John Rooney, Nyack, vice-president, Dr R L Yeager, secretary, Dr M R Hopper, treasurer, Dr S R Monteith, delegate, and Dr F Theis, alternate

Plans for the coming year were discussed at the meeting, and the members reaffirmed their interest in the rising cost of medical care and announced their approval of the United Medical Service and Blue Cross Plan to help defray these costs

A rising vote of thanks was given the retiring

president. Dr E Hall Kline

Schenectady County

Two sessions of postgraduate instruction have been planned for the Schenectady County Medical Society by the State Society in cooperation with the State Department of Health, and are being held at Ellis Hospital, Schenectady on Tuesday nights at

On January 6, Dr Frank Glenn, professor of surgery at the Cornell University Medical College, New York, spoke on "Surgical Treatment of Biliary Tract

On February 3, Dr Richard H Lyons, professor of medicine at Syracuse University College of Medicine, will speak on "Management of Hyperthyroid-ism."

Seneca County

The Seneca County Medical Society has suggested to the Board of Supervisors of the county that Seneca County should have one coroner who also would be the district attorney of the county suggestion was made to the county governing body at its fall session at Waterloo by a delegation from the Medical Society consisting of Dr E P Mc-Wayne, Fayette, Dr David Koch, Seneca Falls, and Dr Charles Smith, Waterloo

The physicians, in making the suggestion that legislation should be adopted providing for this proposed set-up, pointed out that this would result in more efficiency in the county Instead of having four coroners, as at present, who call in the district attorney on many of their cases, the doctors said it would be more feasible to have one coroner who would at the same time be the district attorney

No action was taken on the suggestion, and the supervisors stated that special State legislation would have to be passed to bring about such an arrangement

Steuben County

Dr Vrooman S Higby, Bath, was elected president of the Steuben County Medical Society at the annual meeting on November 13 in Bath, succeeding Dr L A Thomas, Painted Post, retiring president Also elected to office were Dr C E Patti, Hor-

nell, vice-president, Dr Rudolph J Shafer, Corning. secretary-treasurer, Dr W J Tracy, Hornell, dele-

gate, and Dr Thomas, alternate

Three members of the medical staff of the Bath Veterans Administration Center, \mathbf{Drs} Schwartz, A J Giacomini, and Cloyse T Hall, were elected to membership

One of the last units in the State to take the move. the Steuben County Medical Society voted to adopt the Blue Shield Medical Plan of Insurance, Dr R J Shafer, Corning, secretary, has announced plan is owned and operated exclusively by physicians and its headquarters will be in Syracuse, Dr. Shafer stated

Suffolk County

Dr Wilbur Stakes, Patchogue, was elected president of the Suffolk County Medical Society at the 142nd annual meeting held November 5 in Bright-Dr William Carhart, East Islip, and Dr Perry Horenstein, Bellport, were elected vice-presidents

For the 25th consecutive year Dr E P Kolb, Holtsville, was elected secretary, while Dr Grover A. Silliman, Saville, was named to his 20th term as

treasurer

Tompkins County

The annual meeting of the Tompkins County Medical Society was held at Biggs Memorial Hospital on December 15 Officers elected for 1948 were Dr H W Ferns, president, Dr C S Wallace, vice-president, and Dr R Douglass, secretarytreasurer

At the scientific session conducted in connection with the meeting, Dr Leonard A Maynard, director of the School of Nutrition, Cornell University, Ithaca, spoke on "Some Recent Developments in

Nutrition of Interest to Physicians"

Yates County

A resolution endorsing the campaign to raise \$150,000 for a new wing and modernization for Soldiers and Sailors Memorial Hospital, Penn Yan, has been adopted by members of the Yates County Medical Society, and the campaign recommended to all citizens of Yates County as one worthy of their financial and wholehearted support

Note the dates for the Annual Meeting of the Medical Society of the State of New York-

May 17 to 21, 1948, Hotel Pennsylvania, New York City

HOSPITAL NEWS

State Hospital Program Pushed

SUPPORT of Mayor O Dwyer's program for modernizing New York City hospitals was urged by Commissioner of Hospitals Edward M. Bernecker speaking at a meeting of the State Charities Aid

Association in December

Dr Bernecker commended the Association for its constructive criticism and recalled that one of its first achievements was a study of Bellevue Hospital in 1872, which led to the founding of the first hospital

school of nursing in the country

To meet our crying need for more hospital beds, a program for spending \$150,000 000 has been propared as part of a \$350 000 000 long-range plan, Dr Bernecker related. He added that fulfillment depended upon public support of the legislative program presented by Mayor O Dwyer

Herman E. Hilleboc Commissioner of the State Department of Health, declared that current diffi culties were obsolete plant and lack of facilities.

This is the first time in my recollection that we have been able to dare to tall the truth about how desper ate our situation is, he said Not only did Mayor O Dwyer receive our reports and suggestions and criticism in the spirit in which they were made, but he gave them to the public

Dr Hilleboe announced a plan for streamlining administration of his department. He said five branch offices would be established in cities to replace eighteen district offices and creation of more

county public health agencies would be encouraged Other speakers included Dr William A. Brumfield director of the division of syphilis control of the btate Department of Health, Dr Everett Case president of Colgate University, Mrs. Charles president of Colgate University, Mrs. Charles Dana Gibson, chairman of the child placing and adoption committee of the Charitres Aid Associa tion, and Dr George Bachr president of the New York Academy of Medicine

Significance of Birth Rate in Hospital Planning

WHILE 1917 was being acclaimed as a record year for babies and hospitals were urged to expand for other lng years ahead the birth rate quietly passed its peak and began the inevitable downward trend toward prewar levels, the Hospital Council of Greater New York said in a recent bulletin emphasizing the algolficance of the birth rate in hospital planning.

Stating that a total of 4,485 maternity care beds can meet the known needs of New York City resi dents by 1050 the Council recommended the distribution of beds borough by borough through coordinated hospital planning to provide facilities in relation to the needs of the people and to avoid waste in construction and maintenance of facilities of which there (would otherwise) be only fractional

Analyzing the birth rate for New York City as a whole, the Council pointed out that although the rate was very high late in 1946 and early in 1947 the

decline began during March of this year and that since August the number of births per week had actually been lower than for the corresponding week The Council has stated in its Master Plan ın 1946 for Hospitals and Related Facilities for New York City that long time trends in buth rates, etc., altered by changes which occurred during the war and in the carly postwar period, will again be operative by 1050

It is apparent, the Council said, 'that existing facilities are not distributed in relation to population Manhattan, with only 24 per cent of the population, has 38 1 per cent of the beds for maternity care. The Bronx has 19 per cent of the population and only 13.2 per cent of the available beds In Brook lyn the percentage of existing beds approximates the ratio for the population of Brooklyn. Queens, ox pected to have 20 per cent of the total population in New York City by 1950 now has only 10 9 per cent of the total beds available for maternity care

New Clinic Opened for Child Guidance

THE first child guidance clinic for short therapy treatment opened in December at Both David Hospital, Now York City under the direction of Dr Ernest Harms The new clinic which is open on Thursdays only will serve as a pattern for a series of similar ones he plans to develop for social agencies and settlement houses throughout the city

Eighty per cent of the average agency cases brought to the attention of the psychiatrist can be solved by the short therapy method Dr Harms

The director of the Beth David children's ad luminent clinic and author of the recently published Handbook of Child Guidance characterized the clinic work as preventive mental health work where neuroses which may become severe in later life can be diagnosed and treated in time.

Declaring psychoanalysis impractical for the average urban child with neurosis which can be cured by alsorier treatment he said that psychoanalysis is too long and too expensive. The clinic, he ex plained, will serve as a clearing house with severe cases referred for proper treatment.

Types of cases which can be treated at the clinic are truancy mild prodelinquency slight fear neurosis sleeping disturbances, and light neurotic symptoms, he said Pediatrics, psychology and physical examinations are developed, and Dr. Harms has prepared a new type of case-history chart where all these facts are reported on one page

Beth Israel Hospital Establishes Rehabilitation Clinic

BETH Israel Hospital in New York City has announced the establishment of a rehabilitation clinic especially designed for the treatment of patients disabled by cerebrovascular accidents and allied disorders. The purpose will be to treat and train such individuals, the majority of whom would be in the upper age brackets, and who also suffer from hardening of the arteries and high blood pressure, to live useful lives within the limits of their disability

The rehabilitation clinic eventually plans to broaden the program to include other types of disability, but recognizing the urgency of the problem and the immediate need in the beginning, cases will be limited to those patients who have had strokes of anonless or similar disorders

apoplexy or similar disorders

Dr Maxwell S Frank, director of the hospital, stated, "It is our plan to expand the rehabilitation clinic as soon as space becomes available, because in the light of the recent experience in the armed forces and the Veterans Administration, we recognize rehabilitation to be an integral part of medical care" At the present time admission to the new service will be limited to ward and clinic patients

NYU Sets Up Institute for Rehabilitation

THE Institute of Rehabilitation, one of the principal units of the proposed New York University-Bellevue Medical Center, established interim quarters on January 1 at 325-327 East Thuy-eighth Street, Chancellor Harry Woodburn Chase, of New York University, announced in December

The temporary quarters were made possible by the Milbank Memorial Fund and a \$25,000 gift from

Bernard Baruch, Chancellor Chase said The institute, a hospital and outpatient clinic maintained by the University's College of Medicine, will receive patients as soon as necessary changes can be made

A campaign to raise \$2,500,000 for a permanent home for the institute is a part of the current appeal for \$15,575,000 for a new university section of the New York University-Bellevue Medical Center

NEWS NOTES

Sydenham Hospital announced plans for a new building costing \$7,500,000 which will house the present hospital, a research Institute for Medical and Related Sciences and an Institute for Community Relations

The Arnot-Ogden Hospital, the Shepard Relief Hospital of Montour Falls, and the Seneca Falls Hospital were admitted to full membership at the council session

A gift of \$50,000 from the Irving Geist Foundation for the construction of a therapeutic swimming pool for New York University was received by the New York University-Bellevue Medical Center The pool will be built in the institute of Rehabilitation and Physical Medicine, which will be part of the center's new university section

The board of directors of the Council of Rochester Regional Hospitals and the council's medical conference have voted to give full cooperation to the Red Cross in the establishment of a blood bank. The bank would serve eleven counties in Southern-Central New York, including Cheming Thomas R White, Rochester, president of the council and

R White, Rochester, president of the council and charman of the blood bank committee, said that the proposal had been thoroughly studied by the council and expressed the belief that the bank is necessary to provide adequate hospital and medical care in the area

Delaware County which has a 29-bed county hospital at Sidney is being urged, through its board of supervisors, to increase the capacity by a 21-bed extension to the building

The State Department of Health and County Planning Commission recently filed such a report with the supervisor board.

Plans for the creation of a ward at Ellis Hospital, in Schenectady, for the temporary detention of mentally-ill persons have been discussed at a meeting of hospital, city, and state authorities in the hospital

The meeting covered medical and legal aspects of the proposed facilities Dr Arthur W Pense, deputy commissioner, and Dr Walter M Pamphilon, assistant commissioner, will represent the state department of mental hygiene in the discussions Plans must be approved by this state agency before the local program can begin, it was stated

PERSONALITIES

Elected —Dr George H R White as president of the staff of the Geneva General Hospital Other officers of the staff are Dr George C Whitney, vice-president and treasurer, and Dr M J Coyne, secre-

tary As chiefs of the Geneva Hospital services surgery, Dr P H. Skinner, medicine, Dr C W Grove, obstetrics-gynecology, Dr M E Deuel, [Continued on page 223]



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NECROLOGY

Frank T Bascom, M D, of Rochester and Conesus Lake, died on October 21, at the age of seventy-one A practicing physician for 36 years, Dr Bascom was a staff surgeon at Genesce and Highland hospitals for several years and was also a surgeon for the New York Central and Pennsylvania railroads He was the first Rochester doctor to devote full time for surgery He was graduated from Hahnemann Medical College in Philadelphia in 1901

Milton Ralph Bookman, M D, of New York City died on October 4 He was graduated from Columbia University, College of Physicians and Surgeons, in 1906, and was an alumnus of Lebanon Hospital, the Bronx He was a fellow of the American College of Surgeons and a member of the Academy of Medicine

George C Bower, M D, of Marcy, died on December 1, at the age of forty-nine Director of the clinical laboratories at Marcy State Hospital, Dr Bower was graduated from the University of Buffalo Medical School in 1922 He was for a time pathologist at Willard State Hospital Since 1940, he had been an associate editor of the Psychiatric Quarterly, a publication of the State department of Mental Hygiene, and was the author of many articles on both general and neuropathology Dr Bower was a fellow of the American College of Pathology and a member of the New York State Pathology Society, the Utica Academy of Medicine, American Clinical Pathology Association, the Oneida County and New York State Medical Societies, and the American Medical Association

Luke D Broughton, M D, of Brooklyn, died on December 5 He was eighty-nine years of age He was graduated from New York Homeopathic Medical College in 1882

Samuel Friedman, MD, died on December 14, at his home in New York City. He was seventy-two years of age. Graduating from Bellevue Medical College in 1895, Dr. Friedman practiced in New York City for more than fifty years and specialized in internal medicine. In addition to his activities as a physician, Dr. Friedman was well known for his work in Jewish philanthropic and educational circles and as an inventor. He was a member of the American Medical Association, the New York State and County Medical Societies, and the National Gastroenterologist Society.

Clifford R. Hervey, M D, of Oswego, died on October 16, at the age of eighty He was graduated from the University of Michigan College of Medicine in 1893 and served his internship in the Metropolitan Hospital, New York City Dr Hervey practiced medicine in Perry until 1901, moving to Oswego in 1902 He was state district health officer in that community for nearly forty years, having been in charge of public health in Oswego, Jefferson, Cayuga, and Wayne counties since 1916 Dr Hervey was a member of the Oswego Academy of

Medicine, the Oswego County and New York State Medical Societies, and the American Medical Association

Sebastian Lang, M D, the Bronx, died on September 7, at the age of fifty-four He was graduated from the University of Tucbingen, Germany, in 1925 A staff physician at St Francis Hospital, the Bronx, Dr Lang was internist in charge of the thyroid clinic at Lenox Hill Hospital He was a member of the Bronx County Medical Society, the Bronx Medical Association, the American Medical Association, and the New York State Medical Society

Robert Lyness McCready, M D, died on December 14, at his home in New York City—An obstetrician and gynecologist, Dr. McCready practiced medicine in New York City for forty years—He was graduated in 1907 from the College of Physicians and Surgeons, Columbia University, and interned at Lenox Hill Hospital from 1907 to 1910, and later at Lying-In Hospital, New York City—Dr. McCready was a staff member since 1916, and a director and consultant on gynecology and obstetrics at Lenox Hill Hospital—Since 1930, he was a professor of gynecology at the New York Polyelimic Hospital He was a fellow of the American College of Surgeons, a member of the American Medical Association, the New York State and County Medical Societies, and the clinical societies of Lenox Hill and New York Polyelinic hospitals

Kingsley Roberts, M D, of New York City, died on November 21, at the age of fifty-three A graduate of Jefferson Medical College in Philadelphia in 1920, Dr Roberts gave up private practice twelve years ago to establish the Bureau of Cooperative Medicine and later the Medical Administration Service He was a fellow of the American College of Surgeons and a member of the New York State and County Medical Societies and the New York Academy of Medicine

George B Van Doren, M D, died on November 28, at the age of seventy-four A practicing physician in Watertown for nearly 47 years, Dr Van Doren was graduated from Columbia University, College of Physicians and Surgeons, in 1900, and interned at the Hudson Street and Roosevelt hospitals, New York City For many years he was chief of Mercy Hospital's obstetrics division in Watertown. He was Jefferson County physician from 1901 through 1905, serving at the same time as attending physician for the Jefferson County Orphanage

Dr Van Doren became Watertown health officer in October, 1927, continuing as head of the health department until September, 1943, when he retired at the age of seventy Dr Van Doren was a past president of the Jefferson County Medical Society and a member of the New York State Medical Society and the American Medical Society He was also a past president of the medical staffs of Mercy Hospital and the House of the Good Samaritan in

Watertown

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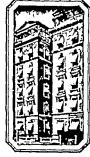
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Bauer, president of the Medical Society of the
State of New York, and an interesting letter from
the Auxiliary president, Mrs Harry F Pohlmann,
the Winter Edition of The Distaff, official publication
of the Woman's Auxiliary of the State Society, has
been distributed to each member, according to Mrs Lee R. Sanborn, editor Copies were mailed on December 16, 1947

In addition to the comments of Dr Bauer and

Mrs Pohlmann, the issue includes reports from the eight District Councilors, an account of the Broome County Health Fair, a special column entitled "Auxiliary Highlights," and several other news items A list of dates for coming events is also given

Members who have not received their copies are requested to write Mrs Thomas D'Angelo, 157-05 Rose Avenue, Flushing, Long Island, New York, who will check to make certain that the name is on the mailing list

COUNTY NEWS

Broome County

Collegiate bridge was played by members of the Broome County Medical Society Auxiliary at a dessert luncheon, November 11, in Endicott Mrs Frank G Moore was general chairman, assisted by Mrs Frank G Baston and Mrs John Kalb Vincent Maddi was in charge of reservations, and Mrs Wilber J Kerr was in charge of the tourney At the business session, Mrs Windsor R. Smith,

president, presided

Columbia County

Dr Leonard D Carpenter, Germantown, president-elect of the Columbia County Medical Society, was guest speaker at the November meeting of the

Woman's Auxiliary, on the topic of medical insurance Mrs Ralph F Spencer, president, announced that members had been invited to attend the midyear luncheon meeting of the Albany County Auxiliary, December 10, at the Albany Country Club when Mrs Harry F Pohlmann, Middletown, State Auxiliary president, was guest of honor

Erre County

The Eric County Medical Society's Auxiliary is now in its second year of establishing and maintaining a scholarship loan fund for student nurses. This year the Auxiliary voted an additional amount, making a total of \$700, for two complete scholarships at the University of Buffalo

Due to the acute shortage of nurses, the Auxiliary voted in 1946 to establish this project, and formed a committee which met with executives of the New The Association York State Nurses' Association recommended that the fund be maintained as a loan rather than a free scholarship, and offered its services

in contacting applicants Each spring all schools of nursing are notified that the loans are available and a notice is sent to the Bulletin of the Nursing Association To date, the Auviliary has found it advisable to interview only girls who have been tentatively accepted by some school of nursing

Ene County now has four students in training, and the reports of their progress are most gratifying

Oneida County

Discussing "Functions and Purposes of the Auxiliary," Mr Thomas E Walsh, field representative of the Medical Society of the State of New York, addressed the Woman's Auxiliary of the Oneida County Medical Society at a luncheon meeting, November 25, in Oriskany

Plans were made for a dance for members and

their husbands in January

Mrs Philip L Turner, president of the Oneida Mrs Philip L Turner, president of the Uneida County Auxiliary, has been chosen by the Business and Professional Women's Club of Utica as the "Woman of the Year" and received their 1947 Scroll of Honor Mrs Turner has been active in the Players' Club, the Y W C A., the Newcomers' Club which she organized during the war, in musical circles and in church work, and lately in forming a discussion group for young methers. discussion group for young mothers

Oswego County

Sponsored by the Woman's Auxiliary to the Oswego County Medical Society, a Charity Ball was

held at the Hotel Pontiac, Oswego, on December 27 Auxiliary members are engaged in various activities in their communities, it is reported. Women of Oswego have been working on a campaign to raise money for a new hospital in that city In Fulton, 452 children were inoculated at the diphtheria clinic in October, with Miss A C Culkin, an Auxiliary associate member, in charge Many members worked on their local Community Chest drives

President of the Oswego County unit is Mrs A J

Cincotta, Fulton.

St. Lawrence County

The first anniversary of the Woman's Auxiliary of the St Lawrence County Medical Society was celebrated at the November meeting in Ogdensburg Mrs John E Free, president, was in charge, and Mrs John S H Mason, councilor of the Fifth District, was guest speaker

[Continued on page 223]

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BOOKS

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RECEIVED

Colloid Science A Symposium Contributors E K Rideal, A. E Alexander, D D Eley et al Octavo of 208 pages, illustrated Brooklyn, Chemical Publishing Co , 1947 Cloth, \$6 00

The Oculorotary Muscles By Richard G Scobee, M D Octavo of 359 pages, illustrated St Louis, C V Mosby Co, 1947 Cloth, \$8 00

Conference on Metabolic Aspects of Convalescence Transactions of the Thirteenth Meeting Naushon Island, Woods Hole, Mass June 10-11, 1946 Edited by Edward C Reifenstein, Jr, M D Octavo of 232 pages, illustrated New York, Josiah Macy Foundation Paper, \$200

Conference on Metabolic Aspects of Convalescence Transactions of the Fourteenth Meeting New York City November 12–13, 1946 Edited by Edward C Reifenstein, Jr., M.D. Octavo of 190 pages, illustrated New York, Josiah Macy Foundation Paper, \$2.25

Recent Advances in Medicine Chinical, Laboratory, Therapeutic By G E Beaumont, M D, and E C Dodds, M D Twelfth edition Duodecimo of 422 pages, illustrated Philadelphia, Blakiston Co, 1947 Cloth, \$6 00

The Thematic Apperception Test The Theory and Technique of Interpretation By Silvan S Tomkins, Ph D Octavo of 297 pages New York, Grune & Stratton, 1947 Cloth, \$500

Ear, Nose and Throat Symptoms—Diagnosis— Treatment By George D Wolf, M D Octavo of 523 pages, illustrated Philadelphia, J B Lippincott Co, 1947 Cloth, \$10

Diagnosis in Daily Practice An Office Routine Based on the Incidence of Various Diseases By

Benjamin V White, M D, and Charles F Geschickter, M D Octavo of 693 pages, illustrated Philadelphia, J B Lippincott Co, 1947 Cloth, \$15

The Clinical Examination of the Nervous System By G H Monrad-Krohn, M D Eighth edition Duodecimo of 380 pages, illustrated New York, Paul B Hoeber, 1947 Cloth, \$4 50

How Life is Handed on By Cyril Bibby, M A Octavo of 159 pages, illustrated New York, Emerson Books, 1947 Cloth, \$2 00

Practical Clinical Psychiatry By Edward A Strecker, M D, Franklin G Ebaugh, M D, and Jack R Ewalt, M D Section on Psychopathologic Problems of Childhood By Leo Kanner, M D Sixth edition Octavo of 476 pages, illustrated Philadelphia, Blakiston Co, 1947 Cloth, \$500

Physical Medicine in General Practice By William Bierman, M D Second edition With a chapter on Medical Rehabilitation by Dr Sidney Licht Octavo of 686 pages, illustrated New York, Paul B Hoeber, 1947 Cloth, \$800

Practical X-Ray Treatment. By Arthur W Erskine, M D Third edition Octavo of 155 pages, illustrated Bruce Publishing Co, St Paul, 1947 Cloth, \$4 50

A Study of Individual Children's Diets By E M Widdowson Octavo of 196 pages, illustrated London, His Majesty's Stationery Office, 1947 Board, 6/-

Laboratory Manual of Microbiology for Nurses By Elizabeth S Gill, B S, and James T Culbertson, Ph D Quarto of 116 pages, illustrated New York, G P Putnam's Sons, 1947 Paper, \$1 50

REVIEWED

Diseases of the Chest. Diagnosis and Treatment By Archibald Reynolds Judd, M D Octavo of 608 pages, illustrated Philadelphia, F A Davis Co, 1947 Cloth, \$900

About half this volume is devoted to tuberculosis, the rest to pulmonary abscess, bronchiectasis, pleurisy, silicosis, and other nontuberculous affections. It is accurate and reasonably up to date but sketchy. In a different format, it would have made a good compendium.

The style is undistinguished except for an almost obsessive use of unnecessary quotation marks. The printing is good and the illustrations and the index

are excellent

MILTON PLOTZ

The 1946 Year Book of Endocrinology, Metabolism and Nutrition Endocrinology edited by Willard O Thompson, M D, Metabolism and Nutrition edited by Tom D Spies, M D Duodecimo of 573 pages, illustrated Chicago, Yearbook Publishers, 1947 Cloth, \$3.75

This edition of the Year Book, as most of its predecessors, contains a wealth of valuable case reports and offers a stimulating wealth of information about the newer trends in endocrinology. The comments of the editor are short and usually to the point

MAX A GOLDZIEHER

Spezielle Chirurgische Therapie für Studierende und Arzte By Max Saegesser, M D Octavo of 884 pages, illustrated Bern (Switzerland), Medizimischer Verlag Hans Huber, 1946 \$24

This book is intended for the use of the medical student and the general practitioner—Exact surgical indications and technic are especially stressed

Although most of the chapters are well covered, accomplishments in surgical treatment of cancer of the esophagus, of congenital anomalies of the heart, and of the large cardiac vessels are not mentioned Conversely, description of operative procedures in the abdominal cavity is much too detailed. The chapters on fractures and dislocations are excellent

RUDOLPH NISSEN

January 15 1048)

Hospital News

[Continued from page 216]

and x-ray Dr W E, Achilles Dr E A Ryken bour as secretary of the Ningara Falls Mumorial floopitals board of trustees As president of the Medical Board of St. Joseph's Hospital, Yonkers, Dr Nicholas R. Locascio

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resident physician at the Indiana, Ponnsylvania,
Horpital and graduate in 1945 of the Collège of
Medical Evangelists Dr Arthur E. Laidlaw Larch
mont, as associate pedilatrician at the Mary Intogene Bassett Hospital, Cooperatown where he has
been acting director of the pedilatric service since
September A graduate of the Vale School of Medi
cine, Dr Laidlaw is also of the staff of the Preshy
terian Hospital and Vanderbilt Cline New York
City, St. Agues Hospital White Plains United
Hospital, Port Chester and is a member of the
laculty of Columbia University Dr David I
Boyd Amsterdam, to the surgical staff of the Labor
Clinic in Boston

Woman s Auxiliary

[Continued from page 220]

Schoharte County

On October 14 the Scholiane County Medical Sodety Auxiliary was organized under the direction of Virs. Herman W Galster Scotia, State chairman of organization making a total of 40 organized units in the State.

Suffolk County

A scholarship for a student nurse will be sponsored as this year's project by members of the Suffolk County Auxiliary Virs Wyron Hafer president, has announced.

To raise funds for this, a benefit dance was held on December 27 at the Riviera Beach Club Brightwaters.

Salliven County

Briming the final total of organized units to 41 the Sulivan County Auxiliary was reformed on Noember 14 as an active organization. A request for 100 per cent New York State organization has been made by Mrs. Davis B Allman national chairman.

Tompkins County

In its first year of existence the Tompkins County Auxiliary has completed an active program, with their immediate aim to educate members in regard to current happenings in health circles.

In October a symposium on "The Present State of the Proposed Health Center" was presented at the regular meeting. The County Health Commission, its outline, set-up and scope was discussed at the November seesion and in January Dr Norman Moore will talk on social medicine.

Alra. Frederick Beck is president of the Tompkins County Auriliary

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True, many of these respiratory diseases are not as dangerous as they used to be. (Modern infection fighting drugs—such as penicillin and the sulpha drugs—offer highly effective treatment for many cases)

But, of course, it is always better to prevent a serious illness whenever possible.

If you have a cold, it's just good sense to stay away

from people, to avoid spreading the infection, and to get plenty of rest-in bed if possible.

If your cold is accompanied by fever, a persistent cough, or a pain in the chest, face, or ear, call your doctor at once.

The sooner you seek his help, the more he can do to help you avoid a long and serious illness

And, in the case of children, an early examination may disclose that what appears to be only a cold may instead be a starting symptom of an entirely different disease, such as measles or scarlet fever

SEE YOUR DOCTOR. Never to the foolhards experiment of dosing yourself Your doctor's treatment of one illness may be quite different from his treatment of another illness which appears the same to you.

Let your doctor diagnose vour ailments. Let lum decide what treatment is best for your particular case. Then follow his instructions to the letter His advice is the only advice you should take on any question that concerns your health.

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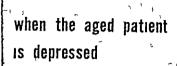
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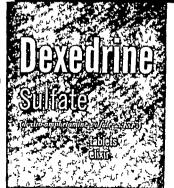
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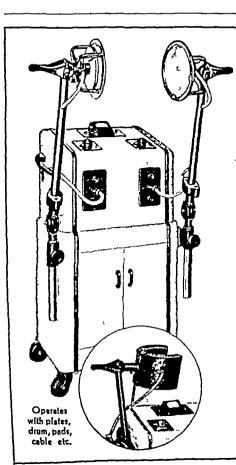
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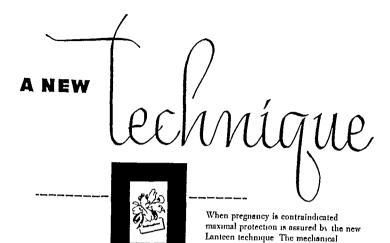
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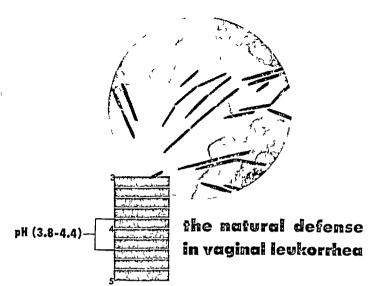
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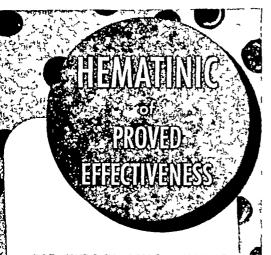
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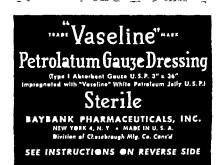
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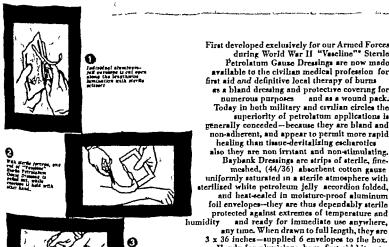
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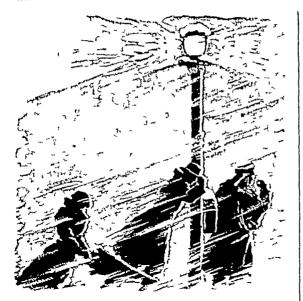
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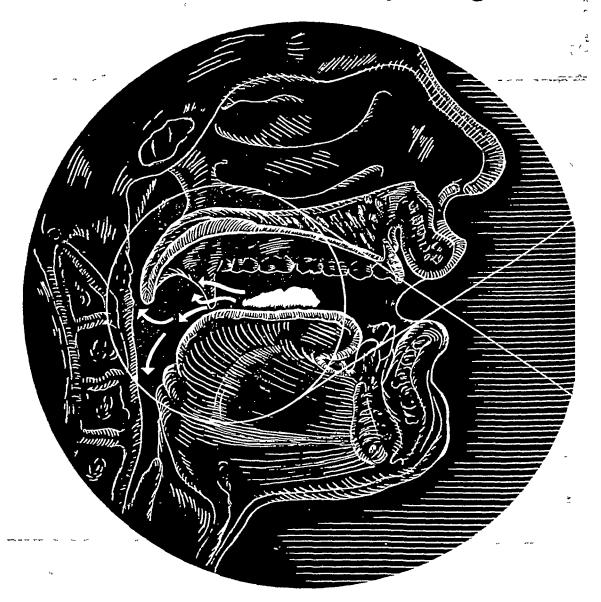
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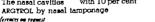
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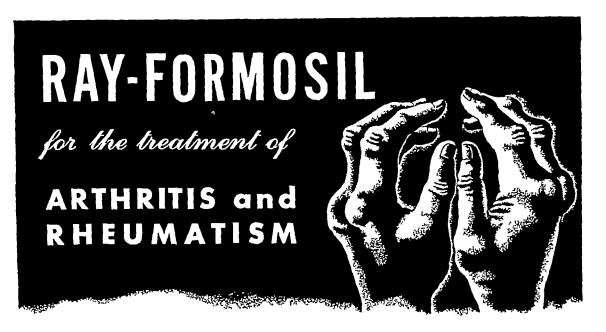
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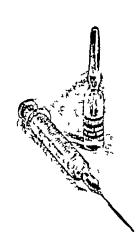
(2) Dann, C. W : Pennsylvania M. J 45:362, 1912,

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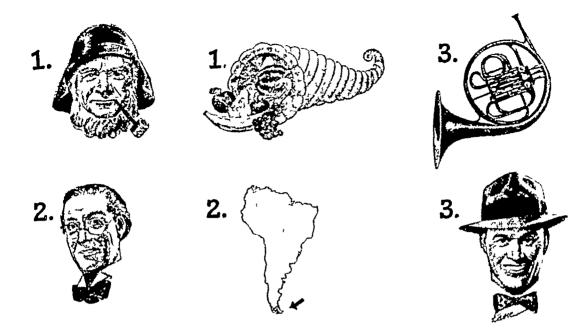
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Alleraic Disorders

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PEDIATRIC

Sedation for

Special examinations Blood framsfusions Administration of parenteral fluids Reactions to immunization procedures Minor surgery

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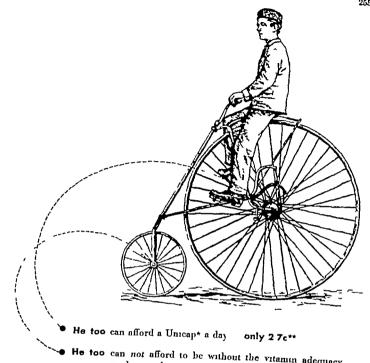
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Editorials

Public Education Needed

Dr Louis H Bauer, president of the State Society, has urged recently in a letter to the membership that each component county society establish, if it has not already done so, a committee on public education

The purpose of this committee would be to provide for the establishment by each county society of its own speakers' group and thereby make available at all times a roster of doctors who are prepared to talk on subjects pertaining to medicine in any of its social, economic, or political aspects. These doctors should be prepared to speak either on their own initiative or at the request of any of the various lay groups within the community

Public education is the most important single thing any county society can accomplish I can think of no better way in which the county society can achieve this than for the Committee on Public Education first, to train and then make available speakers who can give our profession s views on timely topics.

We believe in the private practice of medicine as the proper way to deliver medical care. For certain aspects of medical care, public funds are available If we are to protect the system of private medical care—if we are to insure proper allocation and administration of public funds then the county secrety must provide leadership Otherwise, the public will turn elsewhere for it.

It is perhaps unfortunate that the training of the average man of medicine is not such as to develop many good public speakers. This applies not only to those who address lay groups but also to speakers before professional audiences.

Many will have remarked at medical meetings the obvious difficulty some doctors have in expressing themselves fluently and easily, even when the content of their remarks concerns purely professional matters with which they are thoroughly familiar

In speaking to lay groups, doctors usually find their ordinary public address deficiencies somewhat magnified by the heterogeneous background of their listeners. Medical terms must be paraphrased or translated into ordinary speech. Also, in such groups the doctor may find himself pitted against a practiced public speaker, to the doctor's disadvantage and embarrassment.

But these difficulties can be overcome One recalls the Hibernian who was asked "Hand whether he could play the fiddle one over," says he, "and we'll damn soon find out!" Audiences can be counted on to make allowances if a speaker is obviously sincere, if he has an enthusiasm for his subject, and if he will cultivate the art of persuasion

Savs Dr Bauer

I believe the establishment of a Public Education Committee is most important this committee can find a number of adequately trained men who will go out and discuss these topics, the speakers will so establish the local county society in the minds of the public that the people, and as a consequence both State and local legislators, will automatically turn to the Society for the answer to any medical prob-Likewise, they will turn to the Society for help in finding a solution to any social. economic, or legislative question that touches upon our activities as members of the medical profession

If the medical profession expects the pub-

lic to look to it for information, the doctors. as Dr Bauer states, must train themselves And moreover, to supply it in to supply it attractive and comprehensible form haps the profession is deficient in training for public speaking Let this fact be recognized as a first step in correcting the omission one can speak for the medical profession as authoritatively as the doctors If it is now imperative that doctors prepare themselves to speak to groups of the public, it can be done, because it has to be done

We might suggest that training be commenced in the medical schools with a view to the better fulfillment of medicine's obligation in the future In the meantime, should you desire any information or assistance in planning the creation of a Committee on Public Education and Speakers' Bureau, Dr Bauer suggests that you contact our field representative, Mr Thomas E Walsh, of the Public Relations Bureau at the State Society's office, 292 Madison Avenue, New York, 17, New York

How to Choose a Doctor

Attracted by a full-page advertisement in the New York Times we have just read a most interesting article in the Woman's Home Companion under the above title 2

Every family in the country is advised in the article to get itself a family doctor in ad-Excellent counsel vance of illness and how will the family find one? By applying to the best hospital in town 3 Observe from now on the ever-constant narrowing of the medical field from which the public may seek advice and guidance, if the procedure recommended is followed

Some time ago in New York City there were four "best hospitals in town" Once a year, New York, Presbyterian, Roosevelt, and St Luke's achieved sufficient unity to offer combined examinations for the selection of interns For three days out of the year the four institutions conceded parity

¹ New York Times Oct. 25 1947 ² Albert Deutsch How to Pick a Doctor Home Companion November 1947, p 38 ³ Italics ours.—Ed

Woman s

Conditions have now changed of the Big Four in New York City the field has been narrowed down by two of the Big Four attracting to themselves other institutions, and, with the aid of medical schools, becoming medical centers These two great institutions stand like castles on the Rhine, dominating the approaches to the George Washington and Queensboro bridges

Smaller, most respectable hospitals, with their own traditions of professional excellence, are being absorbed into the maws of these octopi The good reason for their absorption is that it makes them so much more convenient for teaching purposes solidations also cut down the numbers on their staffs and tend to convert independent institutions which formerly fostered healthy rivalries into large conformist-monopolies

Mr Deutsch, the author of the article, lays much stress on picking a doctor who is a Fellow of the American College of Physicians or Surgeons, or is a diplomate of the fifteen Specialty Boards. The field thus is narrowed further

The best hospitals are tending increasingly to be staffed by full- or part-time professors in the medical schools with which they are affiliated, they soon achieve a certain deschment from the problems of the ordinary patient and the general practitioner. Indeed, some of them have never engaged in private practice. Thus they are hardly qualified as general practitioners. Many don't want to treat patients outside the hospital, and some probably wouldn't know how to if they did

Mr Deutsch's article is superficially so good, so plausible, so sweetly reasonable that it gave us to think of the matters which are not mentioned in it but which profoundly affect the result and of which the public should also be informed in choosing a doctor All is not necessarily gold that glitters.

In the plausible scheme propounded by Mr Deutsch, the humble but necessary county medical societies seem to have been entirely overlooked Why? These exist Why should not the public for which Mr Deutsch writes be informed, when choosing a doctor, that a call to the county medical society could be informative and helpful?

Presidents, past, present, and future, of county medical societies are men of broad human interest and understanding. With out having made a very wide acquaintance with all ranks of their profession they could scarcely have been elected to their offices. They are not made independent of human

problems by full-time salaries. They can understand why some very good doctors are not accepted, or may have been rejected by the conformists of the staffs of the best hospitals.

We think the public and the medical profession would both be better off if inquiring patients were referred to a panel of doctors possibly selected locally by such men, as well as to the informational facilities of the best hospital in town We see no reason to bypass entirely the widespread and readily available institutions of established medicine

There is an increasing tendency, among nonmedical writers for the public, to propose new ideas to improve the lot of the citizentaxpayer in his relation to the allegedly reactionary medical profession. We seem to remember a publication of the Public Relations Bureau of the Medical Society of the State of New York in 1942, When Doctors Are Rationed 4 Chapter XVII, p 241, is entitled "How to Choose a Doctor" and was written during the last war at the instigation of the medical profession of this State The book was distributed widely, but apparently not widely enough. Sometimes the more recent nonmedical writers overlook the prior efforts of the medical profession to solve for the public problems which are only apparently new and which are susceptible of other solutions than those advocated by the apostles of neo-liberalism-whatever that is at the moment

By Dwight Anderson and Margaret Baylous, Coward-McCann Inc. New York, 1942.

The Evaluation of Male Fertility

The propaganda wave for contraception which has been so prominent in recent years seems to be in the process of being halted by the thought that more attention should be accorded to relief of sterility as a balancing factor. All of this talk about "voluntary parenthood," "baby spacing," and other popular social measures so widely discussed in lay magasines seems about to be stopped by the thought that perhaps we have gone too far in proventive measures, that perhaps we should seek to increase rather than diminish the number of babies

It is encouraging to note that the birth rate as a matter of fact, has reached a high figure during these past few years. Still there are many barren marriages, and an interest has developed even among service men who are worried because they have no progeny.

Many of these returning servicemen fear that they have acquired sterility as the result of their war experiences, for it is no longer believed that the wife is always at fault As G A. Humphreys has said well in a recent article, "The soldier of yesterday is the father of tomorrow in a hurry to make up for lost time "1"

The causes of sterility of wartime origin may be remote, such as cord injuries or diseases of the genital tract However, accidents similar to those of civilian life, plus lacerating and penetrating wounds, were well cared for with plastic surgery Scrotal damage with shrapnel could be severe without disrupting the continuity of the spermatic passages, and retained fragments have been found to be innocuous Infections, including specific or nonspecific epididymitis, might cause obstruction, or orchitis from mumps, an atrophy Sterility seems unlikely in men who have had filariasis, scrub typhus, malaria, or prolonged atabrine prophylaxis

The evaluation of fertility is important and demands a complete study of the patient, physically and mentally. The man frequently is the cause in a barren marriage and his evaluation simple, although fertility of both partners is essential. Therapy must be based on both general and local factors. Vitamins are important, but hormone medication is of doubtful value except in endocrine dyscrasias. Vasoepididial anastamosis is helpful in obstructive cases.

Dr Humphreys, in this excellent review of the problem, states there is much that we do not know. It may be that in many cases there is a deficiency factor, and if we know what it is, the deficiency may be supplied. But there may be changes in the germinal epithelium itself which are irreversible. This constitutes a challenge to find out what causes bring about such changes and what underlying environmental factors may contribute to this state.

It is evident that a condition of sterility must be approached with understanding of the facts, that both partners, not only one of them, must be studied if we hope to avoid a barren marriage The practitioner may be most helpful in these situations, becoming thoroughly acquainted with a problem may disclose that marital adjustments must need be taken into consideration may be mental as well as physical, and sound advice may be needed rather than medicaments or more radical procedures cause of an individual state of infertility necessarily should be ascertained may not always be a simple procedure, yet we know a great deal more of possible means of relief than was formerly the case The point is to apply our knowledge with discretion.

Current Editorial Comment

Educational Indigestion Some of our readers may have suspected that we were much concerned with the prevalence of mental indigestion in the United States of We have remarked repeatedly the disinclination of employers to take candidates for any kind of position unless they bore a proper label affixed by someone else You can't become a college professor unless you are a Ph D You can't be a Ph D unless you are an AM You can't be an A M unless you are an A B In the army they call this "advancing through the grades" Seemingly, you not only get degrees, but you also brag about them Well, perhaps not exactly brag, but—you know you look down your nose at those who do not have them This is a fact our returned veteran comrades are finding out

It is a curious thing that the United States, a pioneer country, comparatively speaking, should thus become so dependent In a pioneer country a man was frequently judged by what he said he could do So, formerly in a western frontier town, with or without a college degree, it was thought madvisable, for example, to say you were a good shot unless you were. Otherwise, the already proved best shot in town might feel moved to try conclusions with you

Miss Gretta Palmer, in a most informative article, takes up the question of the difficulty sick people have in getting nurses to take care of them ¹ There are plenty of trained nurses The only trouble with them

¹ Pennsylvania M J June 1947

¹ Palmer Gretta What Happens When Trained Nurses Won t Nurse the Sick? Ladies Home Journal 44 50 (Dec.) 1947

is that they don't want to take care of sick people. And we don't much blame them The heads of your school of nursing insist that you have a college degree before you can even become a probationer in a hospital, and that while you are learning to make beds, take temperatures, make patients comfortable, you are whisked from the bedside to attend lecture courses in "physiology, anatomy, microbiology, materia medica, pathology, obstetrics, sociology, pediatrics, chemistry, psychiatry, diet therapy, and a half dozen other academic subjects"

That is what is meant by educating people out of their vocation. Fancy a young girl, a college graduate before she even started her three years' training course, a twenty five-year-old, scientifically trained intelligent acman, being asked on her way back from such a didatic, abstruse course, to stop and rub the back of a sixteen year-old primipara

expecting her first baby!

Florence Nightingale would not allow educational qualifications for her nurses She felt that either you were possessed of, or by, the qualifications that made you a successful nurse or you were not We suppose she felt herself to have intuition, or some such obsolete and unscientific quality. If we ever had to have a bad case of typhoid lever on a desert island, we should elect to have a nurse selected by Miss Nightingale rather than a college graduate primed with the latest nuances of microbiology.

It is not understood how higher education sneaked in and undermined the community judgment that once sized up a man by his ability to perform. But it has It is not known how it has destroyed the simple ambitions of the young men and women who used to aspire to careers in medicine and nursing just because they felt they had a vocation for them But it has Grievous are the results that higher education has already accomplished

The United States is infested, we had almost said is "lousy," with highly educated people who want to do everything except what they were educated to do In our darker moments we are not even sure that their educators know what they were educating them for

We have baby specialists coming out after five years in the Army possessed with the idea of blossoming forth suddenly as general surgeons. Doubtless they feel that those five years have matured both them and their patients too much to enable them to

follow their original vocation. Some holders of perfectly useful M D degrees are content to immure themselves in laboratories and spend much of their lives milking mice. Every qualified general surgeon comes out of the Army hell bent on becoming a specialist, certified by a Specialty Board, so that he can make money fast. Who can blame a man who has given five of his most productive and formative years to the service of his country for wanting to make money, but how many years is it going to take him to do it in that particular way?

Many years ago one of our leading universities started its course in Freshman English with the question "Who I am and why I came to " Many of the aspiring freshmen had great difficulty in answering either half of the question. It was a good question, but we think the students would have been better off had it been asked of them before they over reached the classic

shades of the university

We suggest that the question be revived and that it be asked of the prospective students. Then let it be asked also, and this is far more important, of the educators, "Who am I trying to educate? And what for?"

First Aid Is the present plan of teaching first aid in our public school system all that it might be? With the increasing trend toward higher accident rates in the home, on the farm, on the highways, the importance of a thorough knowledge of and training in first aid increases

It is our understanding that originally the New York State Health Syllabus of the Department of Education included twenty hours of first aid instruction equivalent to the American Red Cross standard course Apparently, more recently, first aid credit for other related subjects, such as science, biology, and the like, has been allowed so that the amount of first aid taught has been negligible

A correspondent comments "even when the full first and course was taught, each teacher was allowed to interpret the maternal as he understood it, therefore there was no standardization, and, to say the least, every opportunity to give out incorrect information which later might prove harmful in application"

Many police departments, apparently, are now recognizing the importance of first aid instruction for their personnel, so that

immediate and proper care may be given

to highway and other casualties

On the other hand, although school superintendents and principals have been agreed on the merits of a standardized course for which Red Cross certificates would be issued on successful completion of instruction, many have felt that they could not rightfully insist on their health education teachers taking a Red Cross instructor's course for the purpose of certification.

This reluctance on the part of school superintendents and principals might well stem from the absence of a definite policy concerning such teaching in the State Department of Education in Albany Certainly if first aid is to be taught in our public school system it should be taught effectively. The fact that the original New York State Health Syllabus included twenty hours of first aid instruction equivalent to the American Red Cross standard course seems to indicate that effective teaching of this subject was contemplated, but seemingly has not been effectively accomplished

Physicians, like other citizen-taxpayers, have children in the public schools and have an interest in the quality of the instruction they receive. If first aid is to be taught, should there be more effective implementation of instruction? We should like to see the matter given consideration by the various agencies concerned in the interest of better, early care of the injured

The Doctor Shoulders More Responsibility When suicide becomes a complaint that affects the young as well as the old, infirm, insane, and hopelessly diseased, it is time that someone paused and took account of stock. No reader of the daily papers can deny that such a situation exists. One hundred years ago it would have been laid at the door of the clergy. The generation would have been spoken of as one that had "lost faith"

The more the medical profession talks about psychosomatic medicine the more it will be called upon to shoulder its share of the blame for early suicides—those who can't or won't give time a chance to solve their difficulties. They will say "Why should I go to a doctor? He will spend an hour giving me a physical examination complete with blood tests and then tell me there is nothing the matter with me"

They will often be right, too There are too many doctors who ignore the fact that, for example, high speed transportation com-

prises two factors the automobile and its The machine may be perfect, but the driver crazy or "accident-prone" The conscientious doctor who tries to practice psychosomatic medicine may lose some important patients who are perfectly willing. even anxious, to admit to a physical disability and who flounce indignantly from his office when he insinuates that their troubles he, to continue the simile, not in the machine, but in its driver These patients will henceforth go about blasting the reputation of the honest doctor and end enthusiastically in the hands of the half-baked psychoanalyst or side-street psychiatrist, the walls of whose office are plastered with imposing looking parchment degrees from such institutions as the College of Universal Truth, or some dubious physiotherapy institute

Our older readers will wag their heads and say, "Our grandparents were never like that"

And they will be right The Atomic Age is a fearful age to live in If the human being has become so intelligent and scientific that he is in danger of blasting to pieces the planet upon which he lives, we can't blame any distracted person for choosing to end it all now of his own volition, rather than await his doom at the hand of some invisible, unknown, and incomprehensible enemy

The truth seems to be that man's intelligence is getting too big for its breeches. In 1870, let us say, children were born in large numbers. Their death rate was appalling. They were "raised naturally." But those who survived were "tough babies." We use

the term advisedly

Since then we have lowered the death rate almost beyond belief. In addition, we now consider the psyche of the child. One generation has not time to grow up before another system of child psychology is being tried upon its younger sibling. Small wonder that there is jealousy and contrasting behavior between brothers and sisters, and anxiety and confusion on the part of their parents.

We invite aspirants to the degree of Doctor of Medicine, and indeed, those who have already attained it, to return to the middle of the road. If they can learn not necessarily to practice psychosomatic medicine, but to recognize that every patient who comes to them is at once the car and its driver, and to treat both at the same time, they will earn for themselves a private and public appreciation that can never be measured or approached by academic degrees or financial remuneration.

Scientific Articles

TREATMENT OF POLIOMYELITIS IN THE ACUTE AND CONVALESCENT STAGES

Physical Therapy and Orthopedic Consideration

ARNO DAVID GUREWITSCH, M.D., New York City Halford Hallock, M.D. New York City, and Roder J. Dugan, M.D., West Haverstraw, New York

(From the New 1 ork State Reconstruction Home)

A LTHOUGH the return of muscle power in poliomyelitis depends upon the number of anterior horn cells that have been involved and the extent to which they have been damaged recovery can be facilitated and the effects of the disease mitigated by appropriate treatment in the acute and convalescent stages.

This discussion of therapy is based on the study of and experience with 552 paralytic partients in the acute and early convalescent stages who were treated from 1942 through 1946 at the New York State Reconstruction Home at West Haverstraw, New York. Until 1945 the patients admitted were under twenty-one years of age Since that time adults also have been admitted

The following treatment aims can be stated (1) to alleviate muscle pain, muscle shortening, and limited ffexibility, (2) to develop optimal function of the weakened muscles, (3) to re-babilitate the patient and make him as useful and independent as possible in the face of his handicap, and (4) to prevent the development of deformity in all stages of the disease.

Physical Therapy

Meat.—Pain is present in nearly every patient. We distinguish between spontaneous pain pain that is elicited when muscles are pressed or gently squeezed, and pain which is present on joint notion.

Spontaneous pain is brought about by posterior hori cell irritation and the pull on painful muscle fibers created by certain positions. Elimination of such pull can be accomplished by positioning the patient or by measures of support, for example, in the supine position a small pullow placed under the patient a shoulders will eliminate a painful pull of gravity exerted by the shoulders on the pectoral muscles.

on the pectoral muscles.

Promatal at the 141st Annual Meeting of the Medical Secrety of the and of New York, Buffal Section on Orthopedis Surgery May 8, 1947.

Pain on squeezing and on joint motion is best treated with most heat. We have been using hot packs extensively Since 1943, our method of choice has been daily baths at a temperature of 104 F for fifteen or twenty minutes repeated three to five times daily depending on the severity of symptoms (Fig. 1) Both packs and warm water are only partially effective. They are cumbersome and far from ideal but in the absence of anything better they represent the best method at present of reducing stiffness and freeing the patient from pain. It is our impression that the baths are more successful than the packs and less unpleasant for the patients. They also have the advantage of not requiring careful localizing of areas of pain and limited flexibility and can be given by any attendant, without knowing the rather intricate technic of hot packs

No exercises are given while the patient is in the bath Passive exercises to all joints are started from admission. With gradually subsiding pain the vigor of the passive motion is in creased and gradually, more and more firm stretching is applied to any joints that are stiff. The amount of existing pain and the status of joint flexibility are recorded at intervals on a special form using standard positions (Fig. 2). The baths or packs are continued as long as stiffness and muscle pain persist and as long as there is a favorable response. With improvement the number of daily packs or baths may be diminished gradually

In a number of instances we have found dry heat in the form of radiant light or short wave to be fully as effective as moist heat especially when the pain or muscle stiffness was localized to a relatively small area.

Exercise —Voluntary control of normal muscles can be educated to much greater efficiency, for example in the development of skills or in learning to play a musical instrument. In



Fig 1 Large swimming pool converted for hot bath routine. Note the head rests, which keep hair and ears dry and prevent the patient from slipping. Note also how carefully patient is being taken in and out of water.

diseases of the central nervous system voluntary control may be diminished or often confused A generally known example is a hemiplegic, who is apt to throw impulses simultaneously into the flexors and extensors of a joint. In infantile paralysis also we frequently see a lack of control in the use of individual muscles. Therefore, the first goal of muscle re-education in poliomyelitis is the restoration of exact control of individual muscles.

The second aim of muscle re-education is the development of maximal power in the remaining functional muscle fibers. By training, a vast reserve of function in muscles can be brought out if systematically increased effort is asked of the muscle fibers. This principle, which is true for

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Fig 2 Record of flexibility and pain

healthy muscles, holds also for those in which a certain percentage of nerve and corresponding muscle fibers have been destroyed

Muscle re-education should be graded carefully, and care should be taken to avoid exhausting a weak muscle If possible, muscle training should be repeated several times a day daily performance of a muscle is the only guide to the optimal amount of effort to which it should be subjected A frequently repeated muscle test, employing the Lovett method of grading, provides a record of progress made. It helps to determine when and to what extent the patient is ready for increased effort (Fig. 3) Individual muscles are exercised for increase of strength as long as the record shows evidence of increasing power If there has been no return of power, we may give up hope in four to six If muscles are improving, we may conmonths tinue exercises up to two years

Special attention is given to the training of the respiratory muscles, which are frequently affected, and to well coordinated breathing

Walking—Since ambulation may represent a source of undue fatigue to weakened muscles, more or less extensively involved patients are started walking very gradually under water At first, they are placed on their feet in warm water up to the neck. This eliminates gravity and stimulates a multitude of postural reflexes without fatiguing muscles by weight bearing. By gradually reducing the level of the water, the amount of weight bearing is graded. If brace

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Fig 3 One page of muscle chart



Fig 4. Walking under water

support for the weakened limbs is needed, the same type of brace that will eventually be used is employed in giving the preliminary under water instructions in walking (Fig 4). As facility increases the patients and gradually allowed to walk on land under supervision and finally, at will in the ward and out of doors.

Ambulation is allowed as soon as it is felt that the upright posture and the effort of walking will not affect recovering muscles unfavorably Braces should be provided when necessary for support or to prevent the development of deformity Preparatory exercises for balance and walking, including development of arm muscles if crutches will be needed are started long before the time for actual walking

Rehabilitation

As soon as no further improvement of strength in individual muscles can be reasonably expected -we take a standstill of three months as a guide—an attempt is made to fe-train as much useful function as possible. A wide range of reserve function is available and can be drawn upon to substitute for loss of muscles under water and awimning are useful aids to training substitution by other muscles, balance and coordinated movement. When the process of degeneration of the affected muscle fibers has reached its end, the fatigue element in handling muscles can be disregarded and training for useful function can be started The end point of the process of degeneration is ascertained clinically by the absence of quick fatigue when the muscle is exercised or more exactly by chronaue read ings

Again, we establish first a record for existing function, using a purely practical approach. The patient then is taught to perform necessary daily activities, such as getting out of bed into a wheel chair, dressing putting on braces, bath room necessities getting up and down stairs or curbs and getting in and out of buses.

There are few patients who cannot be improved by a methodical attempt to improve useful function. We have trained several patients with complete or extensive paralysis of the arms to perform almost all daily activities, like enting weshing dressing with special garments writing by using their feet entirely (Fig 5). Functional occupational therapy, given for the double purpose of recreation and of training of muscles and skills, is used extensively in this phase.

Psychologic Aspects

The importance which we attach to the psychologic aspects of infantale paralyses is emphasized in the setting aside of funds at the Home for study and treatment of the mental phases in the care of the patient. The psychologic impact of the disease with its paralytic and disabling effects is enormous. In the past this has not been given the study and attention that it should have had Recovery rehabilita



Fig. 5 Patient with fiall upper extremities.

tion, vocational training, and, in the adult, job re-training, will be facilitated greatly by a healthy psychologic readjustment

Deformities

Deformities can develop during any stage of the disease. They interfere with rehabilitation, and the ultimate degree of function of the individual depends upon the absence of deformities as well as on the return and development of muscle power. The prevention of deformity, therefore, cannot be overemphasized.

In the early stages deformities are produced by muscle shortening associated with muscle irritability and pain, by habitual faulty attitudes while in bed, and by muscle imbalance, the result of paralysis. They are prevented by the previously described measures of alleviating muscle pain, by not allowing joints to remain for any length of time in faulty positions, and by opposing with mechanical means the deforming pull of imbalanced muscles

Proper position in bed is important. The patient most of the time should be kept in a supine or prone position on a firm mattress with the arms at the side. Pillows or rolled towels should be used to prevent external rotation of the legs, and a cradle should be employed to prevent the weight of the bed clothes from pressing down the feet into equinus. Footboards are used to control foot drop. Variations of this position may be necessary in the early stage to relax a group of muscles that may be in marked spasmodic contraction. If imbalance is present between the



Fig 6 Neglected hip deflexion deformity

flexor and extensor muscles of the hip or if there is marked weakness of the anterior abdominal muscles, prolonged sitting up in bed should be avoided because of the increased danger of developing a hip flexion deformity (Fig 6) Prolonged resting of the hands on the chest or abdomen also should not be allowed, as in this position the wrists are flexed and, if muscle imbalance is present, flexion deformities may occur

Molded plaster of paris splints or bivalved casts are the best means of supporting joints while the patient is in bed to prevent deformity when this is necessary. When he is ready to get up, braces made of steel or duraluminum are employed for the same reason, and in severely paralyzed cases are used to provide stability so that the individual can walk. These must be worn as long as there is any tendency for deformity to develop or until this possibility, or the joint weakness, has been eliminated by reconstructive and stabilizing surgery in the residual stage.

The development of deformity should not be awaited, rather, it should be anticipated. It is far easier to prevent malposition than to correct it. If deformities occur or increase in spite of the early application of heat and stretching, they must be corrected by methods of traction, wedging, or turnbuckle casts.

Surgery

There should be little need for surgery in the convalescent stage, since deformity generally can be controlled by treatment and the appropriate use of splints and braces. If, however, deformities develop and will not yield to conservative means of therapy, surgical correction will be necessary. In the residual stage, surgery of a reconstructive and stabilizing nature plays a major role.

Statistics

Three hundred consecutive cases have been studied for development of deformities and for behavior of muscle strength of a few muscles

TABLE 1 -- DEFORMITIES

				====
	Mild	Moderate	Severe	Total
Scoliosis	40	16	1	57
Hip flexion	16	7	Ö	29
Recurvatum	10	5	1	16
Knee flexion	4	1		
Equinua	85	16	1	$\frac{102}{21}$
Cavus foot	18	3		21

We called deformities mild when no surgery was contemplated, in moderate deformities surgery was likely, and in the group of the severe deformities surgery had been decided upon

Table 2 demonstrates the average improvement of five muscles between the first and last examination We have used both symbols, letters, and figures The key for our evaluation is seen in Table 3

TABLE 2 .-- MUSCLE STRENGTH

	Number of Muscles	Early Strength	Late Strength	Differ
Auterior tibial Cali	303 382	3 17 P 3 50 P+	5 18 F-	2 1 6
Quadricepe Abdominals	40I 414	4 26 P+ 3 68 P+	6 60 F+	2 34 3 25
Deltoid	277	4 27 P.T	6 89 1 +	2 62

These figures are given without comment. The symptoms of infantile paralysis vary widely only much larger groups of patients can form the besis for valid conclusions. It is noteworthy however that the abdominals are the most frequently involved muscles, and that they show a better rate of improvement than the other muscles of the group. The anterior tibuli shows the least improvement of all muscles, which confirms the clinical impression we had. The del told, the only muscle of the upper extremity we followed, has been involved distinctly less frequently than the muscles of the lower extremities.

TABLE 3 -KEY TO MUNCLE EVALUATION

0-0	6-F
1 T	7 P+
0-0 1 T 2-P 3-P	7 F+ 8-0 ~ 9-G
4-P+ 6-F-	10-G+ N
1-0	N

Summary

- 1 A discussion of the physical therapy and orthopedic management in the acute and con valescent stages of poliomyelitis has been presented.
- 2 This was based upon the study of and experience with 552 paralytic patients who were treated from 1942 through 1946 at the New York State Reconstruction Home, West Haver straw, New York.

Discussion

H J Behrend M.D., New 1 ork City — The treatment of poliomyelitis has become a serious probem for the hospitals and for the physicians. Because of the widespread publicity given to this disease, parents and relatives will frequently demand the application of certain methods of treatment for their patients.

The approach to treatment presented here follows threlly the lines of modern physical medicine including reliabilitation and orthopedies. In so doing the authors have clearly come to the conclusion, which coincides with our own, that the nature of the disease makes it impossible to follow the strict commandments of an individual method We agree that the conventional applications of most heat namely het packs and hot baths, are cumber

some and far from ideal. We have used hot baths only occasionally and then not more than once a day. It would interest me to learn the effect of baths of 104 F given for fifteen to twenty minutes and repeated 3 to 5 times daily on the circulation and on other systems of the body. In my opinion a bath of this temperature given so frequently constitutes a mild form of fever thrapy with all its possible complications and weakening effects.

Because we realized all the difficulties with which we were confronted in applying hot packs regularly over a long period of time we have also been look ing for different methods to releave muscle pain

In 1944 I published a report on the pain relieving effect of hydrogalvanism the galvanic bath in subacute pollomyellits. We have used this method ever since at the Hospital for John Diseases in Now York with satisfactory results. The theory of the physiologic effect of this method is based on the accepted physiology of the continuous galvanic current in combination with hydrotherapy. The method has been described in the Bulletin of the Hospital for Joint Diseases, October 1944

The problem of rehabilitation received consider able attention during the last world war. Much has been done in this respect for the injured the paraplegies and the homiplegies Very little has been done in this respect for the victims of polionyelits. The authors have realized the importance of this problem. The teaching of daily activities using the practical approach of vocational training and job training, has been more than neglected in the past. The authors are to be congratulated for their approach to the problem and for their fine presentation.

R. D Severance M.D., Syrucuse New 1 ork—I was interested in the eareful, continuous recording of the various symptoms especially pain stiffness muscle weakness and level of practical function. We too have given hot baths. I would be interested in the experience Dr. Gurewitsch had with the general systemic reactions of the patients to the warm water. We have developed as a guide for determining the end point of tolerance of each bath the appearance of pearls of sweat on the patients is forcheed. We have found that a warm bath acts as the best sedative for pain and discomfort making any medication unnecessary.

If muscles remain completely paralyzed for a few months we have given up treating them every day The muscles are checked by the head physical ther apist once a month for signs of returning power I wonder if Dr Gurewitsch thinks this practice to be adequate.

I believe it is a very good idea to start the stand ing and walking of patients under water climinating entirely the effort of weight bearing. We have found however, that the reastance of the water may interfore quife considerably. I would be interested in the criteria developed for evaluating the limit of fatigue in relation to the amount of effort to which the muscles should be exposed.

Dr Gurewitsch When I went out to Minneapolis to study Sister Kenny's work in 1943 I asked whether she could suggest a use for the three pools which we happened to have at our disposal at the Reconstruction Home in the treatment of polio "The best use I could make of the pools was to fill them with good garden earth and to plant beautiful flowers in them for the patients to enjoy," was the answer I received I am afraid we have not followed this advice

We have watched for systemic reactions care-The patients do develop some degree of fully fever Blonde, light-skinned patients may go up to 100 5 F, or even 101 F Dark-skinned or colored patients show less temperature rise. Since fever therapy has been advocated as a means of getting rid of pain and stiffness, this reaction may not be We give salt tablets, watch for replacement of lost fluid, and check the patient's appetite and weight

In very debilitated patients we have cut the time of immersion down to five minutes once or twice But on the whole we have found that the great majority of patients could withstand the routine described

The temperature of 104 F was chosen arbitrarily We have continued one routine for the entire series in order to get an impression from a large group of patients The coming year we will start, equally arbitrarily, another group treated with a temperature of only 101 F, and in due time we may be able to make a comparison

Sedatives were mentioned. I would like to utter a word of caution Sedatives are dangerous wherever there is respiratory distress We have seen patients become restless, fighting against falling asleep, because the lowered respiratory capacity during sleep got too close to their minimum requirements A further diminishing of the respiration by sedatives may, in severe cases, kill the patient in his

We treated zero muscles differently from zero ex-The prognosis of a zero muscle surrounded by functioning muscles is unpredictable It should receive more intensive muscle reduction than outlined by Dr Severance If the entire extremity is paralyzed, the prognosis is much more definite to the negative, and a speedy attempt, aiming at practical functional education of the patient, is justified

We have not found the resistance of the water for early walking exercises to be an important factor The movements are executed very slowly with attention put mostly on good coordination

Muscles which are still in the process of degeneration or regeneration show signs of fatigue very quickly, in this stage they should not be exhausted by nonsupervised activities like walking. If the exercise is stopped immediately when signs of exhaustion develop, demonstrated by decreasing function, renewed effort within only a few minutes is possible and desirable Treatment sessions, therefore, should be repeated several times daily and the patient, if old enough, should be instructed as much as possible to exercise the weak muscles by The time and type of his exercises should himself be checked daily by the therapist

If we see no improvement of strength after three months, we feel that the approach should be changed We have chosen three months arbitrarily

As to the testing of abdominal muscle strength, we have not been very fussy We have tested muscle groups rather than individual muscles by simple anterior and lateral flexion of head, trunk, and thighs

ANNOUNCE RADIO PROGRAM, "DOCTORS TODAY"

The A.M A.-N B C radio program "Doctors Today," which opened December 13, 1947, is scheduled to run for 26 consecutive weeks at 3 P M each Saturday, Central Standard time. The exact number of stations taking the program will be announced when available, the 1947 series, "Doctors-Then and Now," was broadcast by approximately 140 stations from coast to coast

"Doctors Today" is a program based on timeliness and therefore subject to change The following

schedule is tentative

Whenever possible programs cancelled in favor of more timely ones will be broadcast later in the

27 December 1947—Physical Fitness

3 January 1948—Cancer

10 January

17 January

1948—Care of the Chronically Ill 1948—Alcoholism 1948—Federal Control of Drugs 1948—Urgent Need for Nurses 1948—Health in Rural Schools 24 January 31 January

7 February -A M A News, December 26, 1947

THE EFFECT OF DRILLING THE NECK OF THE FEMUR IN LEGG PERTHES' DISEASE

Isadore Zadek, MD, New York City, and Geoege DB Berkett, MD, New Orleans (From the Hospital for Joint Diseases)

THIS is an analysis of the end result of drilling through the epiphyseal cartilage of the neck of the femur in 10 patients suffering from Legg-Perthes' disease. This work was done in 1942, but its presentation was delayed because of more pressing activities incidental to the recent war

All of the patients were young boys time of operation the youngest patient was five and the oldest, ten years of age. The average age was seven years. Seven of these drillings were performed from within after dislocating the head of the femur from the acetabulum, and three from without, the channels being made through the neck of the femur in the same manner as one performs a blind nailing for fracture of the neck of the femur In order to facilitate this type of drilling, a window was cut in the lateral aspect of the femoral shaft just below the greater trochanter This procedure is not advised for so-called "blind nailing" of the fractured hips as the nail loses an important point of fixation. The window was replaced and countersunk with a bone set after the drill holes were made into the neck of the femur

There is so much more trauma associated with intra-articular drilling and interference with the local blood supply to the head and neck of the femur that this is less desirable than extra-articular drilling. With the former type the articular cartilage of the head of the femur is necessarily traumatized.

In 6 patients the right hip was involved and 4 had the condition on the left. The longest time that elapsed after operation was a check-up twelve years later. The shortest period for check-up was two years

The disease had existed for an average of ten to twelve months prior to drilling. Several cases were excluded for reasons such as insufficient drill holes, lack of conclusive evidence that the criphyseal cartilage had been traversed, or too short a period of observation after operation.

All of the operative incisions healed by primary umon and the only complication was a fracture of the upper third of the shaft of the femur that occurred in one case when the head of the femur was being dislocated from the acctribulum

All of the patients had some protection after operation including bed rest with traction They

remained in bed for about six months postoperatively, although some were kept there for a much longer period of time and were protected, more or less efficiently, for eighteen months to four years Subsequent protection was carried out by plaster of Pans spicas, crutches with a high shoe on the opposite side, or a caliper brace. The caliper brace does not remove the superincumbent weight to any appreciable degree and merely serves to lesson the individual's activity.

Six of the 10 patients had a limp at the time of the final examination Five patients were positive for Trendelenburg a sign, 5 were negative Two of them lacked 5 degrees of full extension while one of them lacked 35 degrees of complete flexion Five patients lacked abduction of 5 to 15 degrees Two cases had no shortening as measured from the anterior superior spine of the ilium to the internal malleolus. The remaining cases had shortening that varied from 1/2 inch to 1 inch and averaged 1/4 of an inch One patient showed atrophy of the thigh of 2 inches and in the others, it varied to as little as 1/4 of an inch In all of these cases but one, in which the epiphy seal line completely disappeared, the epiphyscal cartilage was still evident roentgenographically three to twelve years postoperatively

The patient in whom drilling apparently provoked fusion of the epiphyseal line was ten years old at the time of operation with the check-up x ray examination made four years postoperatively. This drilling was done intra-articularly, they in the end result being a flattened head of the femur. In one case in which the drilling was done extra-articularly at the age of ten the head of the femur was round and globular, and the epiphyseal line was still evident three years postoperatively. There was no shortening at the time of the check-up. The head of the femur in the remaining nine had become flattened and mushroomed to a more or less marked degree.

One of the cases was of particular interest. The disease was bilateral The left side was drilled extra-articularly. The patient remained in bed at our convalescent home for two years with skin traction to both lower extremities. At the end of the two years the side operated upon showed more flattening of the head of the femur than the one not operated upon while the neck of the femur was broader and shorter on the side operated upon

Presented at the 141st Annual Meeting of the Medical Sotiety of the State of New York Buffalo Section on Orthopodic Surgery M y 9 1947

Comment

This series of cases is too small to allow one to draw absolute conclusions

Assuming that the condition is a manifestation of aseptic necrosis with a local vascular disturbance, one might have expected that drilling through the defective area would have assisted in the process of resolution Our examination has not shown this to be true One would, therefore, conclude that the progress in the healing of this disease is not influenced by the drilling

Probably Legg's opinion is correct, i.e., that there are two distinct types of the disease, one in which the head becomes flattened and mushroomed centrally, and the other in which there is a tendency toward flattening associated with more fragmentation and migration of the flattened head toward the greater trochanter ¹ Legg felt that the ultimate result depended upon what type we happened to be dealing with, that the outcome was pretty well predestined, and that the change of shape was not influenced by weight-Notwithstanding this, it seems logical to avoid weight-bearing during the active period when softening is present, as has been recommended by Danforth and others ²

In contrast to the above, drilling through the epiphyseal cartilage does hasten its closure in slipping of the upper femoral epiphysis and in congenital coxa vara 3 It is not readily apparent why this does not occur in Legg-Perthes' disease

We wish to thank Dr S Kleinberg and Dr H Sonnenschein for the privilege of studying cases from their services

Discussion

Joseph Buchman, M.D., New York City-Dr Zadek is to be commended for his frank report on two operative approaches for the cure of Perthes' The drilling of the head and neck of the femur, whether it be via the extra-articular or the intra-articular route, has failed to modify the course of the disease My own experiences were concerned with the drilling of the head and neck from the articular surface of the head subsequent to its dislocation from the acetabulum in 12 instances none of these instances was the evolution of the disease modified to any appreciable degree either for the better or the worse

Dr Zadek rightly calls attention to the oftrepeated observation that drilling in congenital coxa vara and in slipped femoral epiphysis hastens the cycles of these disturbances by the production of early bony union between the head and neck of the femur In Legg-Perthes' disease drilling, no matter how thorough, is without effect planation for the difference in the behavior of the latter disturbance in contrast to the former disturbances may possibly be due to the fact that in Legg-Perthes' disease the area of aseptic necrosis is much more extensive and therefore is not so readily resolved by creeping substitutions as in the congenital cova vara and slipped femoral epiphysis A second explanation may rest in the fact that the area of aseptic necrosis in Legg-Perthes' disease is at the end of the bone and, consequently, presents less opportunity for revascularization than in congenital coxa vara and slipped femoral epiphysis where the disturbance lies between the head and the neck. Both of these consist of relatively normal bone with normal circulation and are, therefore, capable of acting as foci from which creeping substitution may develop

It is perhaps opportune at this time to describe the gross pathologic appearances, noted subsequent to the dislocation of the femoral head in Legg-Perthes' disease In every instance that I have observed the head was of relatively normal shape The overlying cartilage was at times discolored and presented a loss of its usual sheen. There were areas of softening deep to the articular cartilage and loss of attachment to the underlying bone to the extent that if sufficient care were not exercised during the drilling operation the cartilage could readily be pecled off the head much like the cracked shell of a hard-boiled egg The texture of the head, as demonstrated by its resistance to the drill point, was irregularly soft and hard at varying levels In several instances a wedge-shaped section was removed from the inferior aspect of the head These sections presented avascular, necrotic bone The area of juncture of the perichondrium of the neck and the articular cartilage usually presented a velvety cuff of edematous and congested synovial The ligamentum teres was usually thickened, edematous, and congested, and presented a similar appearance to that noted at the periphery of the head Section of the ligamentum teres did not produce any significant hemorrhage and in no instance was it necessary to tie off the contained vessels The point of attachment of the ligamentum teres to the head and its origin in the floor of the acetabulum was usually surrounded by the abovedescribed velvety-appearing edematous and congested synovial tissue

I mention these pathologic appearances to indicate the possible dangers inherent in drilling of the head and neck of the femur in Legg-Perthes' disease It is very possible that on drilling from the greater trochanteric region small fragments of articular cartilage may be torn off and dropped into the joint, with resultant development of cartilaginous bodies within the articulation

Dr Zadek's presentation is important, even though it does not speak of success. Actually it points to procedures which should be shunned. Avoidance of weight-bearing by prolonged bed rest, several years if necessary, yields the most satisfactory results

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PERIARTERITIS NODOSA LIKE LESIONS IN TUBERCULOUS MENINGITIS

MILTON G BOHROD M D, Rochester, New York

(From the Pathology Laboratories of the Rochester General Hospital)

CTUDIES of the past few years in the patho-O genesis of periarteritis nodosa stimulated especially by the researches of Rich and his coworkers, have pointed to the importance of allergy as a mechanism concerned 1 According to this conception, penarteritis nodosa is the result of an anaphylactoid antigen-antibody reaction in which the arteries are the site (the so-called 'shock-organ') of the reaction The experi mental production of penartentis by methods which do not involve such reactions should warn one against accepting this mechanism as the only possible one. However, if periartentia nodosa cannot at this time be said to be the nathognomonic sign of vascular allergic reaction it can nevertheless be accepted as highly characteristic.

In experimental periartentis nodosa a very limited number of antigens have been employed. In the human disease it is rare to be able to designate the actual substance which is involved. The question remains unsettled therefore as to how wide a range of allergens is capable of electing the characteristic response. This in turn has a bearing on the whole question of the causative agents responsible for many allergic vascular, cardiac joint, and other diseases.

Case Report

Case 1—The patient was a twenty-six year-old colored man who entered the Rochester General Reputation July 12 in a stuprous state. The history obtained from his relatives was fragmentary and not too reliable. The patient had contracted a cold in February and since then had had a dull pain in the chest. Since March he had been weak and in the past few months had lost 15 pounds. Two weeks before admission he developed severe headache and lethargy and for some hours he had been semi stuprous.

Examination showed definite signs of meninguits. The spinal fluid, obtained at an initial pressure of 75 mm., was slightly cloudy and on standing developed a pellicle. There were 500 cells per cu mm. 75 per cent lymphocytes and 25 per cent neutrophils. Sagar 19 mg. per 100 cc., chlorides 460 and total protein 184 mg. per 100 cc. On subsequent spinal fluid examinations over a period of three days there was little change except that the pressure rose as high as 405 mm. No micro-organisms were seen in smears, but guinea pigs inoculated with two different fluids developed tuberculous lesions from which tubercle bacilli were recovered.

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The patient's condition became rapidly worse He died on July 17 his sixth hospital day

Necropsy revealed evidence of tuberculosis in the lungs hilar lymph nodes, prostate, and the men inges. The lungs showed small feet of acnosenedese involvement, larger areas of caseous pneu monia, and disseminated miliary tubercles. Military tubercles were not noted grossly in the spleen or liver but they were found on histologic examination. Most of the prostate was replaced by caseous material.

The brain weighted 1,280 Gm. The base was covered by fairly thick gelatinous exudate, which extended over the cerebollum pons and modula. The region of the exit of the fourth ventricle was obstructed and both the fourth and the third ventricles were dilated. Over the convex surface the leptomenings were only slightly thickened and cloudy and along the course of the blood vessels a few pinhead-size gray nodules could be seen.

Except for the vascular lesions the histologic find ings were typical of the usual tuberculous meningitis. The exudate contained considerable fibrin and many cells partly lymphocytes and histocytes, partly neutrophil leukocytes. There was a marked tendency for the exudate to become necrotic, and around the necrotic areas the histocytes tended to congregate and form abortive tuberculoid granulomas. Only rarely was a well-defined tubercic en countered

Vascular lesions were very prominent at the base of the brain where grosely the exudate was thickest every meningual vessel of moderate size and some amall vessels were involved The largest vessels showed no involvement. In the rest of the brain those vessels were involved which were close to regions of inflammatory infiltration. For the most part the typical lesion was a panartentis, less frequently it was simply a periarteritis and a few vessels were seen which showed only an endartentis, or fibrancid necrosis of a portion of the wall. All of these lesions recombled those seen in typical cases of periarteritis nodosa. There was a tendence in a very few vessels for greater necrosis than is usually encountered in periartentis nodosa The pan arteritic lesions caused great thickening of the vessel which stood out prominently in the sections.

The necrotic and granulomatous lemons of the meninges showed moderate numbers of tuberclo bacilli in sections, but the most careful search in many sections failed to disclose a single tubercle bacillus in the vascular lesions

No periarteritic or other arterial lesion was found in any other organ in the body

Discussion

While tuberculous lesions in general avoid blood vessels this tendency is not as marked in

the meninges as elsewhere Frequently, the lesions of tuberculous meningitis follow the course of the blood vessels, and sometimes the vessels themselves are thickened and infiltrated with inflammatory cells The only unusual factors in the case described are the extent of the vascular involvement and the presence of so many stages of lesions frequently seen in penarteritis nodosa

The vascular lesions may be explained as the result of the action of tuberculoprotein on meningeal blood vessels which had been sensitized to this substance, and with the production of perarteritis nodosa-like lesions The apparent absence of tubercle bacilli in the vascular lesions may be of some importance in support of this That the meninges can be sensitized experimentally to other proteins was shown long ago 3 The lesions produced were not dissimilar to the ones shown in this case

This has a bearing on the pathogenesis of tuberculous meningitis in general No one will deny that the condition may follow the rupture of a large tuberculoma into the subarachnoid space But the pinhead-sized or slightly larger lesions, found after painful search, if at all, are more easily explained as the formation of granulomas after the occurrence of the meningitis, for this disease frequently has a duration of several weeks or months The necrotizing character of the lesions, the frequency of vascular lesions, and the sparsity, in many instances, of tubercle bacilli in comparison with the degree of exudation, all these point to sensitization of the meninges as an important factor in producing the meningitis

There remains the problem of the identity of the lesions with those of the disease called periarteritis nodosa This latter condition not only has certain characteristic histologic features, but there is also a characteristic distribution of the lesions among the organs and, usually, a proneness to dissemination, both of which are absent in this instance Yet, isolated organ involvement been reported in periarteritis nodosa Furthermore, in the absence of an identifiable living or chemical agent in the usual case of periarteritis nodosa, the only criteria for naming the lesions are morphologic ones, and these are identical histologically in the well-defined case and in the one here reported

It is evident that tuberculo-allergen is only in exceptional instances a cause of periarteritis The fact that it is capable of eliciting the reaction in sensitized vessels points to the probability that in the more common dissemmated disease a variety of allergens are probably responsible

Summary

A case of tuberculous meningitis is reported in which there were an unusual number of unusually well-defined vascular lesions, histologically identical with those seen in periarteritis nodosa The vascular lesions were, however, limited to the meninges

It is suggested that this represents an instance of the allergic nature of periarteritis nodosa lesions in which the allergen was tuberculoprotem and in which the meningeal blood vessels were hypersensitive to this allergen

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CONGRESS ON MEDICAL EDUCATION AND LICENSURE TO MELT

Some of the most important problems facing medical schools at this time will be discussed at the 44th annual Congress on Medical Education and Licensure, to be held under the auspices of the Council on Medical Education and Hospitals and the Federation of State Medical Boards at the Palmer House, Chicago, February 9 and 10, 1948 Papers on the financial support of medical educa-

tion will provide a highly significant discussion. The addition to the undergraduate curriculum of courses on the clinical effects of nuclear fission and on physical medicine and rehabilitation will be discussed by authorities in these fields The recent intense interest in the subject of general medicine makes the review of programs for preparing students for general practice of particular significance

In addition to the formal program of the congress, several national groups concerned with medical education, research, hospitals, and licensure will hold special meetings

These include the Executive Council of the Association of American Medical Colleges, the Advisory Board for Medical Specialties, the National Board of Medical Evaminers, the National Society for Medical Research, and others -A M A News, December 26, 1947

CRITERIA OF HEALING IN FRACTURES FOLLOWING INTERNAL FIXATION

EDGAR M BICK, M D, New York City (From the Mt Sinas Hospital)

THE problem of bone healing must begin with L definitions. This may appear to be an elemen tary cliché at first glance, but in recent yours those of us who have had contact with large num bers of men treating fractures have found that no actual criteria of healing exist and that most of us have but a hazy notion of what we mean by the phrase T P Murray remarked on one aspect of this fact when he wrote Tigures collected by different surgeons with respect to the normal rate of union of any particular fracture are of comparatively little value because the standard varies so greatly as to what clinical and v ray evidence constitutes union ' However, before a standard can be set, it is necessary to define what constitutes bone healing Does it refer, as some maintain, to the complete restoration of trabecular continuity across the fracture line, or does it refer to gross continuity of the rigid structure of the bone, regardless of its histologic components? Is bone union an anatomic phenom enon or a functional one? Obviously, the answer can be the affirmative in either form and must by the nature of the question be an arbi trary decision. This is not at all an academic question The two possible answers represent a serious discrepancy in time, which is of consi er able practical importance to the patient and to those responsible for his medical care

The process of healing in fractures is in its broader sensa, a problem of phases. There are a number of phases in the tissue reactions of reparative esteogenesis. Two of them are pertinent here. One is the phase of effective healing, that phase of reparative osteogenesis in which the resistance of healing bone to stress and strain is sufficient to permit renewal of its normal functions within reasonable limits. In fractures of the long bones of the upper extremity this means manual work short of severe pressure or torsion in the lower extremity it means ordinary unassisted weight bearing.

The second phase pertinent to the present problem is that of replacement, the phase of reparative osteogenesis during which the dense, fibrous fibrocartilaginous tusue of the internal or definitive callus is replaced by normally constructed bone trabeculae. This occurs concurrently with but much slower than the development of the uniting external callus which is the chief factor in the previously defined phase. Effective bone healing should be the primary concern of the surgeon, replacement in definitive callus is secondary and is for the most part the concern of the osteologist

That effective bone healing occurs in many cases long before the x ray film gives evidence of completion of replacement by definitive callus has become increasingly evident with the experience of recent years. Recognition of this fact has led to a significant reduction in the more or less arbitrary standards of morbidity-time in many types of fractures. This is particularly and strikingly true in fractures treated by internal fixation.

In a recently completed study of the structural patterns of callus following fractures of the long bones, it was found that the rather predictable rules which applied to healing fractures in general did not apply to those treated by methods of internal fixation 2 In fact, it was found that resumption of at least limited function was possible in uncomplicated cases, following rigid internal fixation, long before x-ray films showed any of the accepted criteria of bone healing. The absence or minimal quantity of demonstrable external callus was repeatedly noted in all uncomplicated cases treated by efficiently applied bone Fracture lines remained visible on x ray films long after the patient was actually ambula As early as 1942 Burns and Young reported fractures of the tibla and fibula, treated by internal fixation with plates and no external fixation and that patients were "walking at four weeks 'and 'you get early union with the quickest restoration of function " Such observations have appeared repeatedly during the past few years chiefly from military and naval installa tions publicising the impression gained by many of us who had the opportunities to observe such cases although "four weeks' was somewhat earlier than most allowed for fractures of the tibia.

The esteology behind these observations is important for without an understanding of the process of reparative esteogenesis clinical interpretation may become too facile. James Paget in England and Dupuytren in France recognized the different functions of the external or supportive callus and the internal or definitive callus over a hundred years ago. In fact, Dupuytren is credited with having first employed the latter term. The importance of this distinction has been repeatedly emphasized but seldom appre-

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ciated 1 In efficiently plated fractures the bone plate takes over the function of external callus and permits resumption of function of the bone as soon as its strength, plus that of the consolidated fibrous fibrocartilaginous material of the internal callus, establishes effective healing This internal callus, before the replacement phase defined above is completed, is radiotranslucent and, therefore, appears on x-ray films as an area too often described as "atrophy," "no sign of union," or is occasionally misinterpreted as fracture fragments kept apart by the plate It cannot be emphasized too strongly that this intersurface area does not normally collapse during bone union. it is filled with the firm components of the so-called soft callus and is ossified eventually by replacement with bone cells and trabeculae

Because of these osteogenetic processes, a study of x-ray films offer no positive criteria of effective healing in fractures treated by internal fixation There are, however, important observations of a negative sort Atrophy of the cortex beneath the plate or atrophy about the screws inevitably indicates that these have become loose in a locally This may or may not be necrotic environment the result of infection In recent years, since the introduction of chemotherapy, it most often is not infection In either case it is a sign that the fixation is no longer efficient. The appearance of a considerable external callus is another danger It means that fixation has been madequate or that the fracture was held in poor alignment so that the artificial support of the plate was insufficient to take the place of an external ossific mass In either of these instances the time factor for return to unsupported activity cannot be gaged as efficient internal fixation could

Certain other usual criteria of effective healing in fractures are likewise not applicable to cases treated by internal fixation The method of auscultatory percussion introduced by Lippmann in 1932, which has proved a valuable means of gaging the progress of bone union, is not dependable in these cases 4 The transmission of sound waves through a dense medium upon which the test depends is complicated by the presence of the fixed rigid metal and varies with factors other than ossification Local tenderness, another classic symptom by which healing has been gaged ever since the days of Hippocrates, is likewise not a criterion of effective healing following internal fixation, since tissues over the metal or in its vicinity are apt to remain tender to pressure for a long time

What then are the positive criteria of effective healing in fractures following internal fixation? Until some method is devised in which resistance to stress and strain of a long bone can be mechani-

cally measured in situ without danger of refracture, no accurate determination is possible Since it has been shown that the usual clinical and x-ray criteria are not useful, the matter rests entirely upon the tenuous factors of personal judgment and experience at present Certain of the common fractures have now been observed in sufficient numbers by a wide enough variety of investigators to establish tentative arbitrary standards For example, fractures of the tibia and fibula, efficiently plated, and manifesting no contrary indications, may be permitted the test of guarded weight bearing in six weeks safely After one week of this, an x-ray picture should be In uncomplicated well-healed cases there will be no change in alignment. if further restriction is necessary because effective healing is not vet attained, a slight shift or angulation will be observed on the film Fractures of the humerus treated by internal fixation require no plaster immobilization and in uncomplicated cases may be allowed the test of guarded motion between the fifth and sixth week safely (It may not be long before further observation decreases this time factor by a week) We find that fractures of the shafts of the radius and ulna with either one or both bones plated require six weeks to cover a reasonable margin of safety. The thinness of the shafts in proportion to the length of the leverage upon which the pull of the intrinsic muscles is effected requires a firmer strength of union before activity can be resumed without fear of serious angulation than do fractures in which the apposed surfaces offer a larger area I am not prepared to suggest a time factor for fractures of the femurs as vet. since in these cases the enormous stresses and strains require considerable resistance at the fracture site Most cases of fractures of the shaft of the femur in which internal fixation was applied were complicated open fractures, often severely comminuted or with some loss of substance seldom that bone plates are used in simple fracture of the femur, so that further experience will be required to establish the expected duration of morbidity

The criteria of healing in fractures following internal fixation, then, are special and cannot be interpreted in terms of the criteria of healing in fractures treated by other methods At present, these are chiefly negative in character, that is, x-ray evidences of the absence of complications which indicate weakening of the fixation evidences are local atrophy about the metal or the appearance of significant amounts of external ossific callus A narrow strip of external callus along the plate or on the opposite surface, or a small knob at the fracture line in all that is permissible in normal healing. The only positive criterion is observation for perceptible change of alignment during a short period of guarded function. With these concepts in mind it is not impossible to entertain the hope that the time factor for return to restricted activity, at least, following internal fixation will, with further experience, continue to be reduced in the general civilus population 30 East 60th Street

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NATIONAL CONFERENCE ON RURAL HEALTH IN CHICAGO FEBRUARY 6-7

Featuring the health problems of the rural child, the third annual National Conference on Rural Health will be held in Chicago Friday and Saturday February 6 and 7 1948 More than 500 delegates leaders in child health and welfare work throughout the country representatives of the farm groups and the medical profession and others interested in securing for every child a happy healthy futureare expected to attend

The conference will be sponsored by the Commit-tee on Rural Medical Service of the American Medical Association in cooperation with the American Academy of Pediatries and representative farm organizations. The A.M.A committee, headed by F. S. Crockett M. D. of Lafayette Indiana, is composed of 11 physicians.

More than 40 speakers are on the program for the two-day session Among the speakers on the open-ing morning will be George F Lull M.D. Chicago secretary and general manager of the A.M.A., who will deliver the addresss of welcome Lee Forest will deliver the address of welcome Lee Forest
Hill, M D Dea Moines Iowa, president of the
American Academy of Pediatries, who will discuss
bealth problems of the rural child and John P
Hubbard M D Washington, D C director of Child Health Studies of the American Academy of Pediatrics who will participate in a discussion of child health services.

On Friday afternoon four representatives from

the youth committees of the National Farmers Union, the American Farm Bureau Federation, the National Grange and the National Cooperative Milk Producers Federation will discuss the sub-ject Rural Youth Looks at Health. They will be guests of the American Medical Association dur-ing their stay in Chicago

On Saturday the program will include a discussion of the rural school health program and another on medical service in rural areas. Two of the many participants will be Dean F Smiley M.D., Chicago consultant on health and fitness of the Bureau of Health Education of the A.M.A. and Ralph V Platou M.D., New Orleans, head of the Depart ment of Pediatrics of the Tulane University School of Medicine Speakers at the Saturday lumbeon will be the Honorable Joseph H. Ball U.S. Senator from Milnesots, and Edward L. Bortz M.D. Philadelphia, president of the A.M.A.

The National Health Program of the American Medical Association states that "every child should have proper attention including scientific nutrition immunization, and other services included in infant welfare." In extending this program to the rural areas of the United States the American physician invites the help of the American farm family in protecting the rural child so that his future will be built on a heritage carefully and intelligently

planned .- 4.M.A News December 28 1947

UNTOWARD EFFECTS OF THE NEWER DRUGS

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DRIOR to the current era of medical science I the physician was largely dependent upon naturally occurring botanicals and minerals for his dispensable therapeutic agents. Bromides were employed for convulsions, colchicum for gouty arthritis, guinine for malana and other fevers, iron salts for anemia, iodine for thyroid disorders, forglove for heart disease, opium for pain, mercury for syphilis, ergot for contraction of the uterus, caffein for diuresis, and a variety of herbs and minerals for purgation Each therapeutic agent was effective in selected instances. sometimes the efficiency was high, at other times Most of these preparations are still in use and continue to accomplish great thera-On the other hand, and without peutic good exception, new and improved drugs, which have come largely from the chemical laboratory, have been introduced either to enhance or to replace each of the above-noted agents No wellinformed physician will deny the value of these never drugs Some small loss has accompanied a tremendous gain, however, and the untoward reactions of certain of the preparations in a percentage of the patients receiving accepted therapeutic amounts has led to serious or even fatal results

It is only human to minimize the untoward reactions of a new therapeutic substance in the enthusiasm of discovering and subjecting it to clinical trial It has been observed also that the full significance of an untoward reaction may not be appreciated until after months or even years of clinical trial have elapsed. On the other hand, if the drug were withheld from extensive use during such a period of collection of controlled statistics, patients not included in the control study would be deprived An approximate solution to the problem is essentially in effect New drugs are tried in selected patients by a small group of qualified clinical investigators Following this, if the new preparation has ment, a larger number of physicians is allowed the drug, having been informed of the possible sideeffects as well as the good effects Finally, full and complete evaluation is possible only after a prolonged period of time, meanwhile physicians and manufacturers should be as interested in untoward reactions as in favorable reactions Only in this manner is the comprehensive appraisal of the new preparation achieved

* Presented before the Scientific Session of the Alumni Clinical Day April 19, 1947 Buffalo, New York No attempt will be made to consider all the preparations that have been introduced for clinical use in recent years. Nine only will be considered in this communication. In many instances personal interest has prompted inclusion of the untoward effects of a particular substance. In other instances, extensive clinical use warrants discussion. The untoward reactions of the antibiotics in general use will be presented first.

Penicillin

The direct toxic or irritant effect of penicillin is unimportant except when given intrathecally Amounts as great as 30 million units per day have been administered parenterally with no recognized demonstrable local harm. Quantities of 1 to 3 million units per day may be given daily for several weeks with minimal local effects.

A tabulation of the systemic reactions of penicillin modified from Morginson is as follows ¹ Erythema, blotchy or diffuse, dermatitis medicamentosa, exfoliative dermatitis, angioneurotic edema, urticaria, pruntus, erythema multiforme, erythema nodosa, malaise, chills, fever, nausea, vomiting, mental depression, excitation, confusion, nervousness, dizziness, convulsions, peripheral nerve palsy, epistaxis, petechiae, purpura, serum sickness-like syndrome, eosinophilia, hematuria, and azotemia

The use of large single amounts (30,000 to 100,000 units) of penicillin intrathecally may be accompanied by serious local irritation such as arachnoiditis and transverse myelopathy2 and followed by headache, nausea, vomiting, muscle spasms, convulsions, or unconsciousness reaction is believed to be a direct toxic one for nervous tissue, is not an allergic response, and presumably is a function of the quantity of penicillin employed rather than the concentration It has been recommended, therefore, that not more than 10,000 units of penicillin in 10 cc of fluid be given intrathecally per dose daily injection of this quantity and concentration of penicillin for several consecutive days has not been associated in this clinic with any untoward responses Instances of peripheral neuritis of arms and legs have been reported following parenteral penicillin. The development of neuritis appeared to be unrelated to the site of injection Recovery begins rapidly following cessation of the drug but may not be complete for several months

Tissue sensitivity is probably the most serious reaction to be encountered in the general use of penicillin The antigenic property may be demonstrated by patch tests as well as by the Arthus phenomenon Sensitivity may follow the use of even crystalline preparations It may be immediate or delayed natural or acquired Obviously it is difficult to exclude sensitivity to penicillin as a result of acquired sensitivity to Acquired sensitivity may be produced by parenteral or local application and may not be evident until after a lapse of several weeks Patients with dermatologic conditions demon strate greater sensitivity than others. Particularly important in this respect is the application of penicillin directly to the cutaneous surfaces of the body Evidence is accumulating which suggests that the cutaneous use of penicillin should be condemned as a routine procedure First, it is doubtful whether the topical application of penicillin is endowed with any particular merit. Second, the possibility of sensitizing the patient appears to be greater following cutaneous application than by other routes Finally, a direct sensitivity reaction may be induced which defeats or complicates the intended therapeutic procedure It is concluded that if penicillin is indicated in the treatment of cutaneous lesions it should be administered parenterally in most instances.

The incidence of penicillin sensitivity in pa tients without an allergic history is not more than 2 or 3 per cent. It is considerably higher in patients who have had penicillin previously or who have an allergic history If a patient is sensitive to penicillin and the need for the drug is considered to be great small doses followed by increasingly larger quantities are advisable. Benadryl or pyrabenzamine is recommended as an adjuvant during therapy and for several days thereafter to control certain symptoms of sensitivity The incidence of Hercheimer reactions to penicillin is high in patients with tertiary luce particularly in debilitated persons. Desensitization doses should be considered in Yew of the high incidence of reactions, although they are not necessarily prevented by such a proredure.

Streptomycin

The most comprehensive summary of the toxicity of streptomycin was presented by Keefer in a survey of 1000 cases. The over-all incidence of side-effects was reported as 20 5 per cent. The larger the daily does the greater the incidence. When the daily does was 4 Gm. or greater the incidence of toxicity was 60 per cent. The toxicity of this antibiotic as was

noted with penicillin, is considered to be inherent in the active material rather than in impurities

Although streptomycin has been recommended in the troatment of certain acute and chronic bacterial infections, it is believed that it should not be used if other agents are equally effective and available. In regard to the treatment of tuberculosis specifically it is well to appreciate that streptomycin is no more than a bacteriostatic agent and tends to suppress toxicity but not necessarily to eradicate the infectious process. The greatest value at the moment appears to be in patients with tuberculous meningitis or acute disseminated miliary tuberculosis.

The untoward manifestations of streptomycin may be either acute or chronic Local irritation at the site of injection tends to be more aggravating than following the use of penicillin may be alleviated by the use of procesine in the injection fluid without inactivating streptomycin Central nervous system irritation from the intrathecal use of as great a quantity as 01 Gm. daily has not been reported Headache and flushing of the skin were more common in the preparations used initially and usually appeared within the first few days. Skin eruptions and fever are other symptoms of acute toxicity which may appear early in the course of treatment. The skin rash is nonspecific and promptly subsides after cessation of the drug. Streptomyon may be resumed in a few days if very small amounts are given and the quantity increased slowly and with caution to the previous level The development of econophilia as high as 10 per cent is evidence that streptomycin produces sensitivity. The appearance of hyaline and granular casts in the urine following the prolonged use of the preparation is noteworthy and deserves further study before adequate evalua-The tendency to form casts is reported to be greater in an acid urine

Vertigo and tinnitus are disturbing neurologic complaints Tinnitus appears early, while vertigo may not be noted for two or three weeks after beginning treatment. Deafness has been reported, but according to Keefer this symptom developed in patients with typhoid fever or meningitis and should be attributed to the disease and not to streptomycin ! Vertigo is the most troublesome symptom encountered during the prolonged use of the drug Clinical evidence indicates that most patients who-have received the drug for a period of weeks show some interference with vestibular function The changes are considered by some to be permanent, by others to be transient," but they are not looked upon necessarily as serious in view of the fact that a compensatory mechanism develops by

which visual and proprioceptive functions substitute for vestibular loss

Sulfonamides

Approximately ten years have elapsed since the sulfonamides were introduced into this Each newly discovered preparation offered fresh hope that it would be more effective in combatting infection and possess a minimum Realization of this hope has been of toxicity partial only, and the latest and most efficient sulfonamides still are endowed with toxic proper-Furthermore, the increasing number of persons who are given sulfonamides therapeutically or prophylactically may eventually sensitize a sufficient mass of people so as to constitute a threat to their health should there be a need for reuse of a sulfonamide Dowling and Lepper have reported the incidence of toxic reactions to each of the three commonly used sulfonamides 6 Reactions occurred in 299 per cent of a group of 498 patients treated with sulfapyridine. 11.8 per cent of 321 patients receiving sulfathiazole suffered from toxic effects, while only 7.7 per cent of 660 patients who were given sulfadiazine were so affected The reactions varied greatly in their study, some were serious. most of them were mild

The untoward reactions may be divided into direct toxic, mechanical, and allergic, respectively A more satisfactory means of presenting evidence against the sulfonamides, however, is to discuss the subject according to the organ or system A person receiving sulfonamides for the first time may note a general effect, such as nausea, vomiting, cyanosis, headache, dizziness, or mental confusion, which subsides if the drug is In some patients these symptoms may subside in spite of continuation of the drug Fever, another general reaction, may appear with the initial course of therapy or it may develop later as a sensitization phenomenon cidence of fever with a second course of sulfathiazole is considerably higher than with other sulfonamides Skin eruptions, varying from a mild erythema or erythema nodosa to a generalized exfoliative dermatitis or a generalized bullous eruption, may appear either with the first or second course of a sulfonamide

The use of sulfonamides applied directly to the skin for cutaneous ailments is fraught with even greater danger than with penicillin because of skin sensitization. It is believed that the local application of sulfonamides should be reserved for those few conditions which respond to this form of therapy and do not respond to other forms of treatment

The direct toxic effect of sulfonamides upon blood-forming organs has been held responsible

for the reduction of number of circulating red cells, white cells, and platelets, phenomena not infrequently observed during treatment 8 There is increasing evidence to suggest, however, that some of these changes may be related to sensitiza-Acute hemolytic anemia occurs particularly after the use of sulfandamide and sulfanyri-Evidence of anemia may be noted as early as the first day and usually before the fifth day Anemia develops rapidly and may be severe, but when the drug is stopped and whole blood transfusions given, recovery is prompt Agranulocytosis and leukopenia are prone to follow the use of sulfanilamide and sulfapyridine and, when they appear, do so between the second and third week. Twenty per cent of all children who received sulfonamides in a series reported by Menten had a neutropenia 8 A few had agranulocytosis Large amounts of one of the preparations over a prolonged period of time was held responsible in each instance for a fatal reaction Prior to the use of penreillin, pyridoxine, and folic acid in combatting agranulocytosis from sulfonamide intoxication, the mortality rate was high

There is increasing evidence that sulfonamides affect nervous tissue as well as other types of tissue. Optic neuritis and peripheral neuritis have been observed since the early days of use of these substances. Psychologic disturbances include psychoses, hallucinosis, delusions, and schizophrenic symptoms which usually disappear upon withholding the drug. One case of encephalopathy and renal damage has been reported by Maisel, Kubik, and Ayer. Death followed the intake of relatively small amounts of sulfamilamide, sulfathiazole, and sulfadiazine. Diffuse cerebral and cerebellar changes were noted postmortem.

A considerable volume of data has accumulated concerning the renal changes associated with sulfonamide intoxication 10-12 Hematuria, oliguria, anuria, and azotemia have been reported and in many instances crystals of sulfonamides or the acetylated forms are observed in the urinary Careful pathologic preparations have demonstrated similar accumulations of crystals in renal tubules and ureters - It is assumed from a study of patients who have succumbed as a result of this complication that the crystals are precipitated out in the distal portions of the renal tubules as the urne becomes acid chanical insult and obstruction follow chain of events may occur with sulfapyridine, sulfathuazole, or sulfadiazine Since precipitation in the tubules is enhanced by an inadequate urmary output combined with acidification of urine, the prophylactic and therapeutic indications in the prevention of sulfonamide precipitation include an adequate fluid intake and ingestion of alkaline substances In addition to the mechanical and irritative effects of obstruction from deposition of crystals, the kidneys may be the locus of tissue sensitization. Kidneys of patients dying from sulfonamide into acation in such instances have been examined with par ticular attention being given to the identification of precipitated crystals and none has been found Instead focal necrosis, vascular changes, thrombi in the interrenal veins, and an arteritis point to a sensitization phenomena as being responsible Interesting variations in the acid-base balance of the blood have been studied by Luetscher and Blackman in a small sories of cases of renal failure associated with sulfonamide intoxication 12 Ex tremely high serum sodium and chloride con centrations progressed, meanwhile azotemia and oliguria decreased under appropriate therapy

The occurrence of hepatic damage in children following sulfonamide therapy has been studied by Menten and Andersch 14 They observed various types of lesions at pathologic examination The incidence of liver damage in children suggests that this organ may be more susceptible to toxins in the young than in adults. The insult did not appear to be related directly to the quantity of drug taken A toxic colitis has been observed by Gauss and Weinstein in three patients 18 In one patient sulfathiazole was believed responsible in the two others, sulfapyridine was the offender With the withdrawal of the sul fonamides all symptoms subsided and the colon resumed its normal appearance Cardiac arr hythmias have been observed in sulfonamide in toxication, but otherwise little note has been made of the action of these drugs upon the heart.

The factor of tissue sensitivity has been noted in the preceding discussion of organ pathology and is demanding increasing attention in conaderations of sulfonamide intoxication reactions in this category are interpreted as an allergic response to foreign substances unlike those that may follow the parenteral administration of foreign proteins Subsequent to the use of the drug for the first time the sensitization phenomenon máy not appear for eight or ten days. On the other hand patients who have had a previous course may have an immediate or anaphylactic reaction within twenty four hours The difficulty in diagnosing a senattvity reaction to sulfonamides in a patient under treatment for an acute infection is readily apparent. Several of the signs and symptoms of a toxic reaction are similar to those of the initial The development of urticaria may be of diagnostic help. Also the time of development of symptoms may be a useful cue administration of one sulfonamide does not appear to sensitize a person to one of the other

sulfonamides, nevertheless, the incidence of reactions following the intake of a second sulfonamide is greater in persons who have experienced a reaction with a previously ingested preparation than in those who have a negative history for such a reaction. It is apparent that if a person has had a reaction with one sulfonamide and the need arises subsequently for additional sulfonamides, a different preparation should be considered.

One of the best pathologic studies of sulfon amide sensitivity has been reported by Rich 17 He observed an acute arteritis and penartentis pathologically in patients who had received antipneumococcus horse or rabbit serum and sulfadiasine usually the two were prescribed to-The pathologic findings similar to perartentis nodosa present convincing evidence of the potential harm from sulfonamide sensitiza This problem has been investigated also by French who examined the pathologic material in the Army Medical Museum from 76 autopsies and 2 biopsies from patients who had been sensitized to sulfonamides 13 Acidophilic histiocytes were present in focal and diffuse infiltra tions throughout the body He concluded that 'sensitization of large groups of patients with prophylactic doses of sulfonamide drugs may result in an increase in the number of histopathologic lesions encountered at autopsy Many of the lesions are significant causes of death Increased caution must be observed in the prophylactic and therapeutic use of the sul fonamide drugs for minor infections "18

Sulfonamides should not be prescribed unless there is adequate clinical evidence to warrant their therapeutic use. Optimal amounts only should be given and an excess avoided drug should be discontinued as early as possible. Finally sulfonamides should not be given if other methods of therapy are equally efficacious. It is apparent that the incidence and severity of untoward reactions from sulfonamides have caused them to be considered potentially a more harmful preparation than penicillin. Standardization of doses for penicillin has not yet become precise but no evidence has been forthcoming which shows that an excess of penicillin does any particular harm. Sulfonamides on the other hand become increasingly toxic as the quantity increases.10

Benadryl

Drowiness, nervousness, fatigue nausea hypotension, paresthesias, confusion blurred vision, coloma and chilliness respectively, have been reported as untoward symptoms following intake of bonadryl. In one series, 63 per cent of the patients reported one or more of these symptoms. In a few instances the side-reactions have been

severe and with increasing use of this preparation. or similar ones, other untoward results may be observed 20 Mental lethargy, drowsiness, and paresthesias are presumably intensified side-Vasomotor collapse and a shock-like syndrome have followed the use of benadrvl in acceptable therapeutic quantities Difficulty in coordination and muscular twitchings to the extent of epileptiform movements have been noted on one instance The prompt cessation of untoward symptoms following discontinuance of the drug has tended to reassure physicians in prescribing it The body presumably does not store benadryl, and the possibility of an accumulative action is minimal

Demerol (Meperidine hydrochloride)

The side-effects of demerol usually are not disturbing but include dizziness, sweating, syncope, nausea with or without vomiting, vomiting without nausea, euphoria, headache, and anxiety ²¹ Intravenous injection may be followed by a marked drop in systolic and diastolic blood pressure, hence demerol should not be prescribed by this route. The decrease in respiratory rate following administration of demerol to patients with increased intracranial pressure has led Guttman to issue a note of caution in this condition ²²

Since demerol is effective in the control of pain, it is not surprising that patients may become addicted to the use of this drug without a previous history of opium addiction 23 Not only have patients developed a striking tolerance to demerol but they become physically dependent upon it and develop an intense desire for repetition of pleasant sensations associated with its use The usual therapeutic dose is approximately 100 mg, given not oftener than every three hours From 300 to 500 mg every three hours is not unusual in demerol addiction and in certain cases as much as 4,000 mg per day have been required for satiation The same precautions in regard to addiction should be exercised in prescribing demerol as are routine in prescribing an opiate 24

Thiouracil

A diverse type of reaction is associated with thiouracil therapy in an occasional person Williams has reviewed this subject and lists as possible reactions edema of the legs, headache, nausea, vomiting, diarrhea, jaundice, purpura, hematuria, fever, urticaria, maculopapular rash, arthritis, lymphadenopathy, oral sepsis, and psychosis ²⁵ None of these reactions has led to serious or fatal complications, and cessation of the drug usually is associated with subsidence of the untoward effects. A more serious sequela of thiouracil therapy is leukopenia, which occa-

sionally progresses into agranulocytosis Van Winkle and associates observed an incidence of 2 5 per cent of agranulocytosis in a series of more than 5,000 patients under observation in 328 clinics ²⁶ The appearance of agranulocytosis is most frequent during the second month after beginning treatment ²⁵ It is believed that the time element is more important than dosage in development of agranulocytosis. Age and sex appear to be unimportant. Approximately 30 per cent of the patients with agranulocytosis in the above-noted series died.

Precautionary measures are important in patients receiving thiouracil During the second and third months, particularly, blood counts taken weekly or oftener should be routine other times, and as long as the patient continues taking the drug, complete blood studies should be performed at least once a month first indication of leukopenia or agranulocytopenia, thiouracil should be discontinued the first sign or symptom of systemic toxicity. such as fever, malaise, or sore throat, rigorous anti-agranulocytosis therapy should be started From 500,000 to 1,000,000 units of penicilin daily in divided doses are recommended until evidence of infection has disappeared usually requires a minimum of one week value of other agents is less definitive blood transfusions undoubtedly are helpful Pentonucleotid long has been used for agranu-The value of this drug continues to locytosis be uncertain Crude liver extract and folic acid also have been given a trial Newman and Jones report the development of agranulocytosis during thiouracil therapy combined with folic acid as a prophylactic drug 27 Pyridoxine hydrochloride has been reported by Williams to be of value 25 Since the sulfonamides may depress bone marrow, their use in the treatment of agranulocytosis is contraindicated Propyl or methyl thiouracil has been used too short a time to determine the type and incidence of toxicity, although from preliminary reports they appear to be considerably less toxic than thiouracil

Tridione

The use of tridione was accompanied by few untoward symptoms during the first eighteen months of clinical trial. Skin rashes, lightheadedness, nausea, and blurring of vision in bright light were usually sufficiently mild to justify continuation of the drug in view of its great value in control of petit mal. Recently, several deaths following the development of agranulocytosis, aplastic anemia, and thrombocytopenia have been noted in association with tridione therapy. The severe insult to the hematopoietic system develops several months

after beginning treatment. Once symptoms of profound toxicity have appeared, heroic measures have been instituted without success Large amounts of penicillin and whole blood transfusions have been of no avail. In view of the fatal result of the reported cases a closer control of patients receiving tridione should be maintained Mackay and Gottstein suggest the following precautionary routine tient with a blood dyscrasic should receive this drug Other anticonvulsive drugs should be given a trial first. A complete blood count should be obtained at least once a month on each patient. In women at the time of the menses the blood elements should be watched particularly Patients should report any untoward symptom, especially in relation to symptoms of anemia, agranulocytosis and thrombocytopenia "20 It is also stated that the drug should not be given to patients with renal or liver disease

Bal

Bal, 2,3-dimercaptopropanol or British anti lewinte, a product of war research has been recommended for the treatment of arsenic pol soning, especially arsenical dermatitis acute bichloride of mercury poisoning and chronic gold, cadmium, zinc or copper poisoning 11 The intramuscular or subcutaneous routes com prise the usual means of administration in the treatment of civilian medical conditions. Toxicity has been reported as minimal when prescribed in the recommended doses of less than 3 mg per Kg of body weight for arsenic poisoning and less than 5 mg per Kg in acute mercury poisoning. In a few instances nausea, vomiting headache burning sensation about the face lac rimation salivation, paresthesias of the extremitles, a constriction of the throat and chest and an elevation of systolic and diastolic blood pressure have been observed They appear within fifteen or twenty minutes after the injection Each of these effects is temporary in duration

Nitrogen Mustard

The use of nitrogen mustard methyl-bis(schlorethyl)-amine hydrochloride in patients with neoplastic diseases has opened a new approach to the treatment of selected conditions. It also has given the physician a powerful drug with important side-reactions. Unless great care is exercised during injection local irritation of the sum or thrombophlebitis of the vein may follow. The best preventive is to inject the material into the rubber tubing after an intravenous infusion is running in good order. Nausea and vomiting may appear within one or two hours and persist for a similar length of time. ¹² These symptoms

are less prone to develop if the patient has been fasting for twelve or more hours

The delayed systemic effects may be senous but are interpreted as exaggerated therapeutle responses. The lymphoid tissue may be insulated severely with disappearance of circulating lymphocytes, leukopenia, and granulocytopenia without signs or symptoms of agranulocytosis Thrombocytopenia, purpura, and anemia are additional evidences of toxicity to the hematopoietic system The changes in the peripheral blood may appear within twenty four hours after the first injection The total leukocyte count declines progressively for fifteen to twenty days During the third week there may be a morbid reduction in platelets. Recovery from the leukopenia is not influenced by pentonucleotid, folic acid, or transfusion of whole blood 32 In view of the narrow margin of safety, great caution should be exercised in using the drug and the peripheral blood should be studied every three or four days during and for three weeks after completion of the course The use of nitrogen mustard is still in a highly experimental stage and is not recommended as yet for general use even in those diseases which appear to be benefited, i.e. lymphosarcoma, Hodgkin's disease and polycythemia vera

Summary

The untoward reactions of several of the newer drugs have been recounted. In most instances the side-effects are inconvenient and not serious and subside with cossation of the use of the drug On the other hand irreparable and mortal changes have followed the use of some of the substances in an occasional instance. Prophylactic and precautionary measures should be observed with each drug that has been shown to be potentially harmful. Careful watch should be maintained in each patient even though there is no visible evidence of toxicity To know when to stop a drug is frequently as important as to know when to prescribe it. Finally, it is the duty of every physician who is prescribing either new or established preparations to observe carefully untoward reactions and to report them either to the manufacturer or in a medical publication the number of new drugs increases and we know that this will be a fact, continued vigilance should be practiced

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NATIONAL MENTAL HEALTH PROGRAM IS LAUNCHED

The national mental health program, authorized by Congress in 1946 and implemented on July 8. 1947 by an appropriation of seven and a half million dollars, is now underway, Dr Thomas Parran, Surgeon General of the US Public Health Service has announced

The program calls for activity in three major (1) increased research into problems of fields mental health, (2) increased training of urgently needed personnel, and (3) increased support and stimulation of state efforts to develop adequate mental health programs, particularly in the field of

prevention and early treatment Approximately \$400,000 will be spent during the fiscal year 1948 for research Grants-in-aid are provided to universities, hospitals, laboratories, and other public and private institutions and to qualified individuals With these grants 25 research projects will be conducted in such fields as biochemistry, neurophysiology, delinquency, child psychology, alcoholism, psychosomatic medicine, psychotherapy, shock thorapy The fund also provides research fellowships in fields related to mental

health, of which 14 have been awarded Over one million dollars will be spent for grants to

public and other nonprofit institutions for the development and improvement of facilities for training mental health personnel Grants include 17 in the field of psychiatry, 16 in clinical psychology, 9 in psychiatric social work, and 9 in psychiatric nursing This fund will also provide for training stipends for 70 graduate students in psychiatry, 41 in clinical psychology, 40 in social work, and 58 in psychiatric nursing

Institutions in New York State receiving the grants for psychiatry include Babies Hospital of the Presbyterian Hospital, Columbia University, College of Physicians and Surgeons, Columbia University, and Cornell University Medical College A grant for clinical psychology was awarded the University of Rochester and a grant for psychiatric social work was given to the New York School of Social Work, Columbia University — Mental Hy-

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THE OCCURRENCE OF WATER-SOLUBLE Rh SUBSTANCES IN BODY SECRETIONS

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THE blood group specific characteristics A and B occur in large concentrations in most of the They also are present in the body secretions majority of the tissue cells of the human body The name "blood groups," therefore, is a missit and should be changed to 'tissue groups". In contrast, the occurrence of the Rh factors outside the red blood cells has been the subject of much discussion and many disagreements Wiener and Forer,1 as well as Levine and Katzin,2 claimed that human raliva is free of water-soluble Rh substances On the other hand, Boorman and Dodd found evidences of small amounts of Rh soluble substances in half of the saliva specimens. obtained from Rh-positive individuals. We have demonstrated the occurrence of water soluble Rh substances in the majority of amniotic fluids although only in low concentrations.4 Because of the importance of the subject and the discrepancy of opinions, three human secretions, namely, saliva, gastric juice, and further amniotic fluids, were examined for their content of Rh substances.

Examination of Saliva

Thirty saliva specimens were examined undiluted saliva specimens in many cases were too viscous to be used and had to be diluted with at least equal volumes of physiologic saline solution The diluted saliva specimens were then thor oughly centrifuged and the supernatants used for examination. In order to counteract the possible presence of enzymes known to be active against blood group specific substances in saliva the specimens were divided into two parts. One part was boiled in a water bath from one to five minutes, the other part was not boiled or three instances the results gave the impression that small amounts of Rh substances were present in both the boiled and unboiled preparations but because of the viscosity of the material and the impossibility of further dilution of the specimens the presence of Rh substances in appreciable amounts in saliva could not be determined

Examination of Gastric Juices

An entirely different picture resulted when sastric juices were examined for the presence of

water-soluble Rh substances Specimens of gustric juice for this study were obtained from patients subjected to the procedure of gastric analysis Immediately upon being received in the laboratory, the specimens were tested for acidity or alkalinity with intrazine paper. Acid specimens were neutralized with tenth-normal or normal NaOH solutions to a pH of 72-74 by using phenol red papers. The specimens were then centrifuged thoroughly, and the supernatant fluids used for testing.

The results of the examination of 22 specimens are recorded in Table 1. Two of these came from Rh negative individuals, 20 from Rh positive individuals. Of the 20 specimens obtained from Rh positive individuals, 12 showed the presence of Rh substances and 8 failed to do so. Seven of the positive specimens showed relatively large amounts of Rh substances.

TABLE 1 —Analysis of a Series of 22 Specimens of Gasteic Juice for Re Secretion

ı.	Rl positive	20
	Positive secretors	7
	Weakly positive scoretors	Š
	Non-secretors	g
9	Rh negati 'e	¥
•	Non-secretion	5
	Mon-poctetion	

The method used for the demonstration of water-soluble Rh substances was the inhibition of agglutination technic. An example illustrating this type of exporiment is shown in Table 2

TABLE 2.*—Additination of Rii Cells by Anti Re Globulin After Treatment of the Latter with Captric Juices

Neutra Ilred Gastrio Juice	Gastri	o Juicce fi Peri		oeltive	Gastrio Juice from Rb Nega tive Person
Super natente	No. 19	No 17	No 15	No 15	No. 22
Undiluted 1 5 0	+++	+#+	+++	+ ++ +++	###

Undiluted and 5 times diluted gastric juices (volume 0.05 cc.) were mixed with 0.05 cc of anti-Rh globulin (Kru) diluted 1.20 and incubated for two hours in the feebox (4 C). After standing for ten minutes at room temperature, 0.05 cc of a 3 per cent suspension of Rhi cells belonging to blood group O was added. The mix tures were allowed to remain at room temperature

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for one hour and then were centrifuged at medium speed for one minute and read macroscopically for agglutination

This experiment revealed the following facts (1) Gastric nuice No 22 from an Rh-negative individual did not inhibit the agglutination of Rh-positive cells by anti-Rh globulin Neither did the gastric juice from Rh-positive (3) On the other hand, speciindividual No 15 mens Nos 19 and 17 definitely prevented agglutination of Rh-positive cells by anti-Rh globulin. indicating the presence in these gastric juices of Rh substances which combine with the Rh anti-(4) Gastric juice No 16 prevented agglutination of Rh-positive cells to a certain, but not Such gastric juices have been definite, extent labeled weakly positive for Rh substances

In addition to the 22 gastric juice specimens, obtained from individuals with a known Rh type, 24 specimens were procured from individuals from whom we could not obtain blood for the determination of the Rh factor * A few of these gastric juices contained rather remarkable amounts of soluble Rh substances as shown in Table 3 In this experiment three gastric juice specimens were examined for their content of Rh substances

TABLE 3 —Agglutination of Rh Positive Human Red Blood Cells by Anti-Rh Globulin After Treatment of the Latter with Gastric Juices

Part I —Agglutination Human Red Blood Cells (Rh. Type) by Anti-Rh Globulin

Neutralized Gastric Juice Supernatants	No 5B	Hooper	No 1
Undiluted 1 3 1 9 1 27	 ++ +++	 + +++ +++	+++ +++ +++ +++

Part II.—Agglutination Human Red Blood Cells (Rh₁ Type) by Anti-Rh Globulin

Neutralized Gastric Juice Supernatants	No 5B	Hooper	No 1
Undiluted 1 3 1 9 1 27	- - - + +++	- ++ ++ +++	+++ +++ +++ +++

PART III.—Agglutination Human Red Blood Cells (Rh. Type) by Anti Rh Globulin

Neutralized Gastric Juice Supernatants	No 5B	Hooper	No 1
Undiluted 1 3 1 9 1 27	- - - + +++	++ +++ +++ +++	+++ +++ +++ +++

Decreasing amounts of gastric juice (volume 0.05 cc) were mixed with 0.05 cc of anti-Rh

globulin (Dem) diluted 1 50 and were kept for two hours in the icebox (4 C) After standing for ten minutes at room temperature, 005 cc of a 3 per cent suspension of Rh-positive cells was The mixtures were allowed to remain for one hour at room temperature and were then The experiment was carried out in centrifuged three parts In Part I, Rho group O cells were added, in Part II, Rh, group O cells, and in Part III, Rh2 group B cells For use with the Rh. group B cells, the anti-Rh globulin was neutralized by the addition of the isolated blood group specific substances A and B 5 The results are recorded in Table 3

This table clearly indicates the following facts (1) Gastric juice No 1 failed to inhibit the agglutination of Rh-positive cells by this respective anti-Rh globulin (2) Gastric juice No 5B definitely inhibited the agglutination of all three Rh-positive cells, namely Rh₁, Rh₂, and Rh₀, by the anti-Rh globulin (3) Gastric juice Hooper inhibited the agglutination of Rh, and Rh, cells. but did not at all inhibit the agglutination of Rh2 cells, indicating the qualitative differences of the subtypes of the Rh factor in gastric juices However, this marked specificity as shown in Table 3 by gastric juice Hooper was not the rule, for the majority of gastric juices inhibited both the agglutination of Rh1 and Rh2 cells, provided they contained any Rh substances at all

Examination of Amniotic Fluids

The occurrence of water-soluble Rh substances in amniotic fluids has been reported previously In contrast with saliva, and even gastric juice, amniotic fluid is easy to work with, since it is usually not viscous and is relatively poor in pro-By means of one anti-Rh serum, which was obtained from a patient in large amounts and which proved to be most suitable for examining amniotic fluids, the presence of Rh substances could be demonstrated in at least 4 out of 5 amniotic fluids originating from Rh-positive babies At that time the following conclusions were drawn (1) Rh substances do occur in amniotic fluid Careful selection of Rh antisera is essential, as not all such sera are suitable for the detection of Rh substances in amniotic fluid (2) The baby's and not the mother's Rh type determines the presence of Rh substances in amni-(3) There are Rh positive cases in which the Rh substances are not secreted, so-(4) The secretion of Rh called non-secretors substances into amniotic fluid is independent of the secretion of the blood group specific substances (5) Amniotic fluids of three erythroblastotic babies did not contain water-soluble Rh substances, and thus these Rh-positive babies belonged to the group of non-secretors

^{*} We are obligated to Dr Ellen Eckstein for obtaining the material under discussion.

TABLE 4.—ADDITINATION OF REI CELLS BY ANTI RE GLOBULIN APPER TERATMENT OF THE LATTER WITH NATIVE AND CONCENTRATED AMPRIOTIC FLUIDS

Amniotic Fluids from Rh-Positive Babies							Amniot from E blastoti	ie Fluid rythro- le Baby		
Liquor Amnii	No.	247	No.	356	No.	259	No.	B09	No.	170
Preparations	Native	Cone.	Native	Cone.	Native	Cona,	Nativo	Cone.	Native	Сове.
Undiluted 1:3 1:4 1:5 1:16 1:32 0	##	1111+++	###	##		1 - 1 - 44+	## ### ###	‡‡‡ ‡‡‡ ‡‡‡	† † † † † † † † † † † † † † † † † † †	### ### ### ###

However, two major difficulties were encoun tered in examining ammiotic fluids for Rh substances. First of all, in certain instances the content of Rh substances was so weak that the interpretation of the results was not definite Secondly, there seemed to be considerable difficulty regarding the Rh antiscrum used for the examination. As a matter of fact, many anti-Rh sera were not suitable at all for these determina

In order to clarify and further strengthen the evidence submitted, attempts were made to con centrate and purify the Rh substances occurring in amniotic fluids. At first, purification of the material by chemical means, such as precipitation with alcohol, acetone, and other agents used for concentration purposes, was attempted ever, the Rh substances seem to be rather clusive and sensitive when exposed to chemical reagents For that reason we finally used the following procedure Amniotic fluids were first spun down in the centrifuge at high speed and sedimental material removed as far as was possible. The fluids were then filtered through a hard paper filter, using gentle suction, and were dialyzed for approximately twenty hours against cold running tap water and for two hours against distilled Water (4 C) Any precipitates occurring were removed by centrifugation, and the remaining clear fluids were dried by lyophilization purification, amniotic fluids were concentrated 10 times, that is for each original volume of 100 co d annuotic fluid that was dried, 10 cc of physiclogic saline solution was added for resolution

The next experiment, as shown in Table 4, was carried out in the following manner Decreasing amounts of (a) native amniotic fluids, and (b) 10 times concentrated amniotic fluids (volume of each 0.05 cc.) were mixed with 0.05 cc. of anti-Rh globulm (Kru) diluted 1 12 and moubated for two hours in the icebox (4 C) After standing for ten minutes at room temperature, 0 05 cc. of a 3 per cent suspension of Rh; cells belonging to blood group O was added After being shaken well, the mixtures were allowed to remain at room temperature for one hour and were then centrifuged at medium speed for one minute and read macroscopically for agglutination.

The experiment shows that the specificity of the reaction is maintained inasmuch as the amniotic fluid (No 179) obtained from an erythroblastotic baby, known to be a non-secretor. did not inhibit the application of Rh positive cells by anti-Rh globulin even after the fluid was concentrated 10 times. On the other hand, one of the amniotic fluids (No 259), known to contain Rh substances, considerably increased its inhibitory power following concentration inhibitory power of amniotic fluid (No 256) increased only slightly The examination of the native amniotic fluid (No 247) would appear to reveal the presence of very slight amounts, if any, of Rh substance However after purifica tion and 10 times concentration, excellent inhibition resulted Amniotic fluid (No 309) did not change at all, as a matter of fact, it proved less inhibitory than before dialysis and concentration We are inclined to interpret this result as an indication that this amniotic fluid does not contain Rh substance and must be considered a non-

secretor The simple method of dialysis and concentra tion seems to allow more definite differentiation between secretors and non-secretors of Rh substances as far as amniotic fluids are concerned The problem of weak secretors can be decided one way or another Concentration has shown, as was expected, that some of the weakly inhibiting native amniotic fluids actually contain Rh substances which could easily be demonstrated by this procedure. This is in direct contrast with others which, after processing, failed to do so and, therefore, could definitely be classified as nonsecretors.

Conclusions

The occurrence of Rh substances in saliva could not be determined with any degree of cer-

no aggiutination
to faint aggiutination
dist aggiutination
marked aggiutination
the strong aggiutinati

tainty If present, they were in such low concentrations as to make their demonstration impossible, at least by the methods used in these studies, because of the viscosity of the material

2 Rh substances in a water-soluble form are excreted into at least half of gastric juices and into an even larger percentage of amniotic fluids. Whether this difference in percentage distribution is an actual one or due only to the possible damage to the Rh substances caused by the chemical treatment of gastric juices before they can be examined, cannot be determined at present

3 The simple method of purification and concentration of amniotic fluids, as described, seems to allow more definite differentiation between secretors and non-secretors of watersoluble Rh substances

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DISCUSS HUMAN HEALTH BEHAVIOR

Dr Dean F Smiley of the AMA. Bureau of Health Education took part in a symposium held in connection with the annual meeting of the National Association of Biology Teachers, December 30, in Chicago The meeting was held in conjunction with the annual session of the American Association for the Advancement of Science and was particularly for teachers of the secondary schools on the subject of behavior

In his paper on "The Contributions of Medicine to Human Health Behavior," Dr Smiley pointed out the error of the traditional belief that the medical profession is only incidentally interested in preventing disease and developing positive health. On the contrary, among physicians themselves, it is well recognized that the most effective way to attack disease is to apply constructive and preventive

The medical profession not only provides many facts as a basis for establishing new habits or modifying old habits, but it also makes it its business to apply these new facts. Among the ways in which medicine applies new found facts are (1) in advising patients regarding their personal hygiene, (2) in administering the public health programs, (3) in carrying on public health education, and (4) in contributing to school and college education

Dr Smiley made a plea to scientists, physicians, biology teachers, science teachers, health educators, and physical educators to set about equipping our young people with the kind of health knowledge that will enable them not only to better understand the modern world's increasing complexity but also to utilize to the fullest its increasing opportunities—A M.A. Secretary's Letter, January 5, 1948

INTERNATIONAL SURGICAL ASSEMBLY

The Sixth International Assembly of the International College of Surgeons will be held in Rome, Italy, at the invitation of the Italian Government, during the week of May 16 to 23, 1948, under the presidency of Professors Raffaele Bastianelli and Raffaele Paolucci of Rome, and Mario Dogliotti of Turin The secretary of the Assembly is Prof Giuseppe Bendandi of Rome

Attendance is not limited to the membership of the college, all surgeons in good standing in their medical organizations are invited. Scientific meetings, scientific and commercial exhibits, visits to the Universities of Turin and Milan have been arranged, together with tours to other medical centers in Europe.

A special evhibit of ancient texts on surgery is being arranged by Prof Davide Giordano of Venice, honorary president, under the active presidency of Prof Adalberto Pazzini, professor of history at the University of Rome. This extraordinary exhibit dealing with ancient surgery will be on display in the Vallicelliana Library in one of the historical buildings of the Vatican.

Detailed information may be obtained from Dr Max Thorek, general secretary, 850 Irving Park Road, Chicago 13 For travel information, address the All Nations Travel Bureau, 38 South Dearborn Street, Chicago, the official travel representatives for this Assembly

Those desiring to present scientific papers address Dr Karl Meyer, Cook County Hospital, Chicago, Dr Henry W Meyerding, Mayo Foundation, Rochester, Minnesota, or Dr Herbert Acuff, Acuff Clinic, 514 West Church Street, Knoxville, Tennes see

PROTHROMBIN TIME IN RHEUMATOID ARTHRITIS

Louis W Granters MD, Broad Channel, New York

(From the New York Post-Graduate Medical Achool and Hospital)

THE use of gold salts in rheumatoid arthritis I may cause hepatic cell damage in any one of three ways direct injury to liver cells, hemolyals with injury to liver cells either directly or by products of hemolysis, or by means of hypersensitivity or allergy 1 While it is true that 25 per cent of patients treated with gold salts sooner or later develop a akın rash, stomatitis, or gustrointestinal symptoms, most of these reactions are of a mild character Since the publication of Hartung's and Freyberg's studies, the trend in this country is toward smaller doses of gold salts 43 Large doses of gold salts by mouth or intravenously given to animals produce destructive and fatal legions in the liver and kidneys. Tone hepatitis, however, is an infrequent sequela. The toxicity of gold, like that of other heavy metallic salts, depends to some extent on the dosage employed

On the whole a laboratory test in liver disease is not very distinctive and its chief value lies in its revealing in a rough measure the ability of the liver to perform a certain specific function. Our problem was to determine whether or not there would be prothrombin deficiency following the use of gold salts and if so, whether the administration of vitamin K with bile salts would be

ational therapy

Method

In the laboratory of the New York Post-Graduate Medical School and Hospital the Link Shapiro modification of Quick's method for determining blood prothrombin levels is used 4.8

Blood samples were taken by mixing 0.9 cc. of blood quickly with 0.1 cc of tenth molar sodium coalstc. The exalated blood was centrifuged at 1.700 revolutions per minute for ten minutes. The clear plasma was then transferred with a pipet to a test tube. The clotting time of the plasma should be determined at once, but if it is stored in a refrigerator, the plasma will remain fairly stable for several hours.

If diluted plasma is to be used, 0 1 cc is transferred into a 75- by 10-mm test tube and diluted with 0.85 per cent sodium chloride. To obtain a plasma concentration of 12 5 per cent, 0 1 cc of plasma is diluted with 0.7 cc. of saline solution The diluted plasma is mixed thoroughly and placed in a constant temperature water bath at 7 C. The plasma is mixed conveniently by

holding the test tube firmly near the top with the thumb and index finger, and striking the lower end sharply with glancing blows with the index finger of the other hand. This accomplishes a thorough mixing without contamination.

With a 0.2 co pipet (micro blood sugar), 0.2 cc. of the thromboplastin-calcium chloride suspension is transferred into 100- by 12-mm test tubes. These tubes are placed in a rack beside the diluted (or whole) plasma samples in the constant temperature bath. As soon as the contents of the tubes have reached the bath temperature, the clotting time of the plasma is deter

mined as follows

The diluted (or whole) plasma is shaken again and transferred with a 0 1 cc. pipet (micro blood sugar) to a tube containing 0.2 co of the thromboplastin-calcium chloride suspension The diluted plasma is blown quickly from the pipet same time the stop watch is started. (The stop watch is conveniently operated by a foot treadle.) The tube is tapped sharply to mix the solutions This insures a uniform initiation of the clotting process throughout the solution stirrer made of No 22 nichrome wire with a loop on the end is now introduced During the clotting process the solution is stirred at such a rate the the stirrer loop sweeps across the test tube from one side to the other two times per second. The end point (formation of the clot) is that point at which the fibrin clot is sufficiently stable to be drawn to one side by the stirrer, thus bring ing into view a clear area. The clot is usually somewhat turbid, since the calcium ovalate formed upon calcifying the oxalated plasma is enmeshed in the clot. The formation of fibrils which impart a viscous appearance to the solu tion before the clot forms, can be disregarded The number of seconds required for clot formation 15 recorded

Normal standards are as follows whole plasma prothrombin time—14-17 seconds, di luted (12 5 per cent) plasma prothrombin time—37-42 seconds. It is always advisable to determine the activity of the thromboplastin by determining the prothrombin plasma elotting time for whole as well as diluted plasma in order to determine whether the figure falls between the above values. (This material should be kept under refrigeration as its activity decreases if not properly stored.)

TABLE 1

Prothrombin Time							
Patient	Prothrombin	(Dilute	Solganal B				
	Time*	Plasma) †	Dosage				
1	12 5	88	10 mg weekly				
2	15 5	87	25 mg. weekly				
3	14	42	25 mg. twice wk.				
4	18 5	38	25 mg. twice wk				
1 2 3 4 5 6 7	18 6 18 5	87 88 5	25 mg. weekly 25 mg. weekly				
8 9	14 12 15 5	44 84 48	25 mg. weekly 10 mg. weekly 25 mg weekly				
10	15	43	25 mg. weekly				
11	12 5	88	25 mg. weekly				
12	13	30	25 mg. weekly				
18	12 5	35	25 mg. weekly				
14	13 5	37	25 mg weekly				
15	15	35	25 mg weekly				

Normal-14-17 seconds. † Normal-37-42 seconds.

Discussion

Prothrombin is a constitutent of blood plasma formed in the liver and is believed to be a pseudo-An adequate supply of vitamin K is essential for a normal blood coagulation 6 Consequently, adequate hepatocellular function and vitamin K absorption are essential for normal plasma prothrombin concentration wide range of safety in the prothrombin factor so that the coagulation time may remain within normal limits until 80 per cent of the prothrombin

of the blood has been lost. When the concentration of the plasma prothrombin falls below 30 per cent of normal, the prothrombin time becomes longer than 20 seconds, the upper limit of normal All of the following patients treated at the Arthritis Clinic were on continuous gold therapy for at least one year with solganal B and crude liver extract intramuscularly. The first and eighth patients had had a mild gold dermatitis

Summary

(Table 1)

In 15 patients treated for one year with therapeutic doses of solganal B and crude liver extract, there was no increase in the prothrombin

which disappeared when the gold was stopped

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"DOCTOR JONES" SAYS-

A fellow, awhile ago, was telling me about some of this new airconditioning business. If you wanted it warmer or cooler or wanted more ventilation or more or less humidity, all you had to do was turn a knob or something And, you know, I was thinking if we could regulate our mental attitudes like that we'd live longer, accomplish a lot more in life and do it easier

There's no doubt but what a considerable part of our difficulties, our failures, and the wear and tear on our system-it's the result of fear that we won't be able to do the things we want to do or think we ought to More or less unconsciously we build up obstacles that don't exist 'til we've created 'em

Remember the little poem (I learned it when I as a boy) about the fellow "Somebody said that was a boy) about the fellow it couldn't be done But he, with a chuckle, replied That maybe it couldn't but he'd not be one To say so 'til he tried' —and so on' My mother, when I was small, told me there was 'no such word as 'can't'' Well, like some other things, I took it too literally I found it, later, in the dictionary, so I concluded she must've been wrong. But the idea she was trying to convey-I recognize now word that's greatly overworked

When we get some understanding of how our minds work and the part our imaginations play in our lives it's possible, if we've got the intelligence, backbone, and perseverance, to cultivate healthy mental attitudes It ain't as easy as just moving a switch or turning a knob but it can be done—up to a certain point Anyway, it's worth trying and 'l'll try' is a lot more stimulating slogan than "I can't"

If we can sift out the imaginary and unnecessary obstacles we'll be in better shape to deal with the unavoidable ones Like the old fellow I heard of down in the Ozarks He was sitting on the porch rocking due north and south. On the other end, in another rocking chair, his son, age forty, was rocking due east and west Finally the old man spoke up "Listen, Zeke, don't rock that-away," he said "Turn your chair round Rock with the grain and save your strength"—Paul P Brooks, MD, in Health News, December 22, 1947

THE OXYTOCIC USE OF METHERGINE IN THE THIRD STAGE OF LABOR

John E. Tritsch, M D , Edward Schneider, M D , and Edmund F Longworth, M.D , New York City

(From the Department of Obstetrics and Gynecology, Metropolitan Hospital)

IN AN effort to substantiate further our ex periences in a preliminary series previously reported by us, we are presenting at this time 711 additional cases in which the new ergonovinelike substance, known as methylergonovine,* has been used

The partial synthesis of an ergot alkaloid has been successful for the first time and has made it possible to produce a large series of isomers and homologues of ergonovine. These have been subjected to accurate pharmacologic analysis and it was found that great differences exist in their effect on the uterus of animals

Among the most powerful of these partially synthetic substances, methylergonovine (Methergine) stands out particularly In comparison with the natural ergonovine, its effect is somewhat stronger and more prolonged in laboratory animals. It also was shown to be the most potent among fifteen derivatives which were subjected to pharmacologic examination in the rabbit uterus.

Third Stage Technic

In our preliminary series of 200 cases, 101 were tiven 1 ce, of Methergine containing 0.2 mg, per cubic continued in the control of the placenta. In the other 99 cases, the same preparation and does were given intravenously immediately following birth of the child and before the placenta was delivered. In both groups, the blood loss was measured for thirty minutes after delivery of the placents.

In the cases handled by the intramuscular method, a modified Credé maneuver was used to deliver the placents. In the cases handled by the intravenous method, the placenta was delivered by the Brandt maneuver?

In all cases, the blood loss was measured accurately in the following manner. A sterile metal parawas placed beneath the patient set buttoeks. Extending from this pan was a trough emptying into a raduated container which was at all times under the direct vision of the accoucheur. This container was on a movable arm which could be maneuvered by the operator's knee in order to avoid inclusion of amniotic fluid and other possible dilluonts.

Clinically in this further study of the 711 cases, there were 209 primiparae and 442 multiparae The operative including elective low forceps in primigravidas was as follows

* Methergine was supplied by the Sandos Chemical Works. Inc., New York City

Primigravidas Multigravidas	New Series 136 23	Old Series 15 5	Total 151 25	Percentage of Total 50 50 5 47
Total Series			179	23 07

The average blood less in this series of 711 cases, in which the drug was administered intravenously immediately after the birth of the infant, was as follows

	Primiparae	Multiparae	
Operative	190 55 co.	142 64 cc.	
Nonoperative	101 02 cc.	93 41 ca.	

It is interesting to note the incidence of blood loss over 500 cc. in this series. The preliminary series of 200 cases had 5 cases or an incidence of 2.5 per cent. The present series has 10 cases or an incidence of 2.68 per cent, or a total of 2.4 cases in both groups for an incidence of 2.65 per cent.

The average blood loss in each series was as follows In the group of 101 cases receiving Mether gine intramuscularly the average blood loss was 183.07 cc. (gross) In the first series of 99 cases receiving Methergine intravenously, the blood loss was 113.24 cc. (gross) In this series of 711 cases in which Methergine was given intravenously the average blood less was 116 17 cc. (gross)

The blood lose calculated on a percentage basis in 100's of cc. is presented in Table 1. A number of interesting observations can be made from this table. For example, 617 per cent of the patients who had Methergine by the intravenous route at the delivery of the baby and before delivery of the placenta lost less than 100 cc. of blood, whereas, in those where Methergine was given after delivery of the placenta, only 31 6 per cent lost less than 100 cc. There were 21 cases out of 810 (intravenous route) and 3 cases out of 810 (intravenous route) and 3 cases out of 101 (intramesular route) in which the postportum bemorrhage was over 500 cc. The highest blood loss in any case was 2,050 cc. There were no fatallities in this series.

TABLE 1.—Calculation of Blood Loss on Percentage Basis

Blood Loss	Intravano Number of Cases	us (810) Percent- age of Total	Intramuse Number of Cases	Percent-
0-100 ec. 101 200 ec. 201-300 ec.	498 178	01 7 21 9 8 3	32 38 15	31 6 37 6 14 8
301-400 cc. 401 500 cc. 501 cc. and over	66 32 17 21	8 9 2 1 2 6	5 5	7 8 4 8

It may also be interesting to note the effect of general anothesia upon blood loss. In Table 2, the cases are divided into two categories, those which received general anothesia and those which did not. Original Series

TABLE 2—Supplemental Data on the Effect of General Anesthesia on Postpartum Hemorrhage

	General No General	
	General Anesthesia	No General Anesthesia
Primiparae	130 55 cc	71 63 cc
Multiparae All Patients	143 33 cc. 131 65 cc	92 13 cc 88 32 cc.

The latter included local, caudal, pudendal block, etc. as well as patients who received no anesthesia either because of precipitated delivery or some other It is clear that general anesthesia increases by about 50 cc the average blood loss

Average Length of Third Stage-Minutes 7 68 (intravenous group) 10 38 (intramuscular group) Original Series

6 91 7 01 (intravenous group only) New Series Total Series There were no constitutional or local reactions in any of the cases However, manual removal of the placenta was necessary in 4 cases of the final series

and 3 cases of the preliminary series, for a total of 7 cases and a percentage of 0 86 per cent Davin and Morris, using ergonovine (Basergin) with the same technic, state "In the entire series

of 1,600 cases, retained placentae requiring manual removal occurred in 20 cases, an incidence of 1 2 per cent "3

According to Monrad E Asberg and Duncan E Reid (Harvard University), manual removal of a retained placenta following delivery of a viable infant was performed 217 times at Boston Lying-in Hospital from 1929 to 1943 During that period, 45,602 patients were delivered of viable infants Thus, manual removal was performed once in every

210 deliveries (0 47 per cent) Indications were hemorrhage per se and retention with hemorrhage "Use of oxytocic drugs These authors further state following delivery did not appear to be significant in retention of the placenta"

Comments

- After further clinical experience with 711 additional cases, plus the 200 previously presented, we find Methergine nontoxic
- The drug seemed definitely to reduce postpartum blood loss as compared to most available statistics
- 3 The administration by intravenous route accelerated the delivery of the placenta by about 31/2 minutes on the average and further reduced blood loss
- Incarceration of the placenta occurred in 0 86 per cent cases, all easily removed

Conclusions

We continue to be of the opinion, after a trial in 911 cases, that Methergine is an efficient and a nontoxic ovytocic drug

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ATOMIC ENERGY EXHIBIT AT MUSEUM

A comprehensive exhibit on atomic energy, the largest of its kind in the country, is now on display at the American Museum of Natural History, Central Park West at 77th Street, New York City, where it opened January 21 and will continue for two months through April 5 The exhibit is sponsored by the Brookhaven National Laboratory, nuclear research center for the Northeast, under the auspices of the US Atomic Energy Commission

Installed in Education Hall of the Museum, the exhibit is open to the public during regular Museum hours, which are on weekdays and Saturdays, from 10 AM. to 5 PM, and on Sundays, from 1 to 5 PM Special group tours of the exhibit may be arranged by organizations, by request to the Museum The exhibit includes a demonstration of nuclear

fission as it occurs in an atomic pile, with striking visual and sound effects caused by the actual breakup of uranium atoms A radium-beryllium source valued at \$10,000 is the neutron source in the "model atomic pile" The model was conceived by Dr John R. Dunning, scientific director of Columbia

Beneficial applications of nuclear energy are suggested by exhibits such as an "atomic power plant, which shows by special lighting effects how an atomic pile may be adapted to provide heat energy to drive electric turbo-generators An animated "pin ball" panel shows the breakup of U-235 atoms in a chain reaction

"Mr Atom," a large silhouette, demonstrates how a radioactive substance may be introduced into the human system to guide doctors in the diagnosis and treatment of ills Other demonstrations show further uses of these radioactive "tracers," and include the special instruments which are used to follow the course of radioisotopes used in biologic, chemical, and medical investigations

INTRACUTANEOUS INFLUENZA VACCINATION

HERMANN VOLLMER, M.D., New York City

THE value of immunication with inactivated influenza virus vaccine has been well established for adults.1-3 Similar data for children are lacking. We do not know the proper age nor the optimum desage for immunication, nor are we informed about the duration of an effective immunity We do know, however, that the procedure requires repeated injections and that the resulting reactions are quite discouraging The mjection is painful, and severe general reactions ensue in a great percentage of cases. Even generalized convulsions have been observed 4

An attempt was made first to find a method which avoided such untoward reactions and was more acceptable for the unmunication of children Absence of general reactions and satisfactory immunologie responses have been reported in the past following the intracutaneous administration of typhoid vaccine 1-11 diphtheria toxoid,12-14 and scarlet fever toxin,13-14 Smaller amounts of antigen injected intracutaneously seemed to produce the same degree of immunity as larger subcutaneous doses of the same substances. A clinical trial of intracutaneous influ enra vaccination therefore suggested itself

One hundred and twenty three children between the ages of 2 and 16 years received a single intracutaneous injection of 0.1 cc of influensa virus vaccine, type A and B, prepared by centrifugation from the extra-embryonic fluid of the chick embryo and formalin killed . The vaccine was injected into the extensor surface of the forearm None of the children had a history of egg allergy

The intracutaneous injection was followed in every case by an immediate burning pain lasting for about one minute. No one complained of pain at any later period Within five minutes after the injection, an erythema of 2 to 8 cm in diameter developed, followed by induration which gradually disappeared within two to five days. While this local reaction faded, slight Itching was noticed by about 10 per cent of the children. A moderate swelling and tenderness of the regional lymph nodes occurred in 21 children. Only 3 children developed a tempera ture up to 100.5 F within twenty four hours following and probably due to the immunization

This intracutaneous method of influenza *Supplied through the courtesy of Dr. H. D. Pierama, Lederle Laboratories Pearl River New York.

immunization is relatively free from disagreeable Whether it gives adequate protection could not be determined. While this study was being completed, a report of van Gelder, Greenspan, and Dufresne appeared, comparing the effects of subcutaneous and intracutaneous in fluenza vaccination 10 The antibody titers were determined by a modification of the Hirst red cell agglutination inhibition test in large groups of Navy personnel.20 These authors found that following a single intracutaneous dose of 0.1 cc of influenza virus vaccine a considerable rise in the serum antibody titer occurred rapidly, reaching a level in one month of several times that obtained by a single dose of 10 cc of the same vaccine administered subcutaneously

Conclusions

A single intracutaneous injection of 0.1 cc. of influenza virus vaccine in 123 children was not followed by disagreeable local or general reactions which occur frequently after the subcutaneous injection of larger doses of this agent.

According to van Gelder, Greenspan, and Du fresne, this intracutaneous immunization produces higher serum antibody titers than the subcutaneous administration of 10 cc. of the same vaccine

A clinical trial of this method appears desirable

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PEDIATRIC APPROACH TO THE MANAGEMENT OF ALLERGIC ECZEMA IN CHILDREN

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MANY of the papers on eczema have left out of consideration the needs of the pediatrician who first sees these cases. It is he who must make the diagnosis and give some relief for this malady, which is a trying experience both for the affected child and its parents. I shall not attempt to cover the subject fully, but rather to emphasize some of the salient features in an effort to orient the pediatrician and to offer some suggestions for the immediate management of this condition.

General Considerations

A typical infantile eczema usually presents an erythematous and oozing appearance and may involve the face and scattered areas on the body and extremities. The condition is highly pruritic, and evidence of bleeding scratch marks are the rule. At times it may be localized, but in other instances it may be so widespread as to affect practically the entire body. Many infantile eczemas clear up before the end of the second year without any recurrence. However, the dermal manifestations may be succeeded by asthma, a respiratory expression of allergy.

Eczema may persist in recurrent episodes throughout childhood and even into adult life, either in conjunction with asthma, or as a dermal allergic entity This chronic form of eczema, which is best designated as allergic disseminated neurodermatitis, and is perhaps the most difficult form of eczema to eradicate, tends to become localized in the neck, the flexures of arms and legs, and the dorsa of the hands assume chronic characteristics in the form of papules, fissures, excorations, lichemfication, and dark grayish plaques The lesions are very pruntic, and the skin shows the evidences of scratching Positive allergic skin tests are the rule, and the causative substances are multiple Psychogenic disturbances are present in most

Secondary bacterial infection is often present, but mycotic involvement, although present at times, is not the rule. It is important to appraise

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, Section on Pediatrics, May 8 1947

the character of the lesions carefully to determine whether there is a superimposed infectious derma-Even when the dermatitis is allergic, one should bear in mind the possibility of concurrent skin infections such as impetigo, trichophytosis, epidermophytosis, pyogenic infection, scabies, pityriasis, dermatitis venenata, dermatitis resulting from overtreatment with medicaments, e.g., phenol, the mercurials, and other substances, and skin irritations due to mechanical factors Specific treatment must be instituted for their correction before the allergic phase is tackled A case comes readily to mind of a young infant who was recently sent to me for the treatment of a diffuse infantile eczema The condition gave all the appearance of allergic dermatitis, but careful study proved it to be a widespread case of scabies It was gratifying to discover later that the young father, who had recently returned from the war, had scabies, and that the mother as well as other members of the family acquired it anti-scabetic therapy resulted in a marked recession and gradual clearing of the skin. Had laborious allergic studies been attempted, they would have proved futile

While one may have to admit that a greater susceptibility to allergy does exist in certain children born of highly allergic families, it does not appear that the actual age of onset of eczema is greatly influenced by genetic factors fants under one year of age we found that eczema was the presenting syndrome in 90 per cent of the The average age of onset of eczema in infants under a year was one and nine-tenths months, and the average age at the time of observation was six and five-tenths months further of interest to note that of all the allergic syndromes, the period between the age of onset and the time that medical attention is sought is shortest for eczema In a study of 250 allergic children we found that 45 per cent suffered from eczema, whereas in the adult allergic antecedents of these patients the number of eczema cases was only about 10 per cent, showing that this disease is particularly related to childhood From these figures it is apparent that eczema is the prevailing allergic condition in infancy and that it starts considerably earlier than any other allergic syndrome

Positive allergic akin reactions were obtained in 85 per cent of the patients under one year of age While 100 per cent of these positive reactors were sensitive to foods, only 41 per cent reacted to foods alone, and 59 per cent reacted to a combination of foods, inhalants, and contactants

Much as been done to solve the riddle of eczema in infants and children since the advent of the allergy concept. Despite the large number of papers concerned with this problem, there is per haps more confused thinking here than in any other field of allergy. Much of the confusion anses from the use of the terms eczema and der matitis. Let, because of such extensive usage both terms will have to be retained, to be used interchangeably at times and at times specifically

One can use the term irritative dermatitis or contact dermatitis to signify a skin condition due to any irritant that will in given concentration and under given circumstances affect practically all human skins Thus, a nonallergic dermatitis can be caused in the normal skin by contact with a physical or chemical agent. Examples are the typical diaper rash seen in early infancy as a result of chemical irritation, or the dermatitis resulting from the mechanical rubbing of the child's clothing These are characterized by varying degrees of inflammation which may cause the destruction of the cutaneous layers and even the subjacent tissue The localization and relation to the causative factors make them readily recog nizable, and simple treatment by climination of the offending agents affords complete relief

With a dermatitis due to allergic sensitization, variously known as eczema, infantile eczema, atopic eczema, atopic dermatitis, allergic derma titis or disseminate neurodermatitis, contact dermatitis or contact eczema, the problem becomes particularly muddled, for one investigator or another has set up criteria sharply differentiating one from the other For example the following criteria have been set up for an atopic derma titis or atopic eczema (1) positive family history for allergy (2) specific reaguns (circulating antibodies) demonstrable by passive transfer (3) positive scratch or intracutaneous tests, (4) usu ally negative patch tests, and (5) the offending substances should be protein in nature other hand, cases suffering from contact derma titis are characterized by (1) a negative family history (2) absence of circulating antibodies, (3) absence of positive intracutaneous reaction, (4) positive patch tests and (5) sensitivity to substances not necessarily protein in nature Hence, they would have us differentiate these two types of dermatitis, even though both are allergic in character and arise from an antigen-antibody cellular union

We shall not enter into the controversy which

has emanated from this differentiation. Rather, we shall state categorically that unless more con vincing proof can be offered in support of the thesis that contact dermatitis and atopic eczema do differ in their basic mechanism, we shall adhere to our opinion, held for many years, that they are both mediated by the same mechanism and should be designated as allergic dermatitis, to be studied and treated on the basis of antigen-antibody interactions. They differ only in the mode of sensitiantion, so-called atopic eczema usually resulting from intrinsic contact with antigens and contact dermatitis from extrinsic contact.

It is little wonder that it is difficult to engage the interest of the pediatrician in all the phases of The time must soon arrive, how this subject ever, when the salient facts, gleaned from the maze of work that is being carried on, will be formulated into broad principles that can be more readily applied in general everyday practice. The present paper is offered to the general pedia trician as a tentative working basis for the management of the allergic case of eczema he so frequently encounters. The problem is difficult, but the immediate treatment can be handled intelligently without elaborate allergy testing If the ecrema is to be firmly rooted out, however, after the skin is cleared, the child should be studied intensively to determine the exact offend ing substances not only to eradicate the eczema but also to prevent asthma from developing

Management

The following are the procedures which I use preliminary to skin testing to clear the skin.

Food -All eczema cases are immediately placed on an allergenically denatured diet fitting the needs of the patient. These denatured foods, in which the albumin and globulin fractions have been coagulated by moist heat are as follows evaporated milk, pablum, pabena, thoroughly cooked cereals thoroughly cooked vegetables thoroughly boiled meats, hard-boiled eggs and stewed fruits. In addition, the following foods are eliminated raw fruits fish, nuts condiments chocolate, as well as the raw or lightly cooked forms of the permitted foods diet is essential to reduce or negate the entrance of any native proteins into the blood stream via the intestinal wall. Ascorbic acid is prescribed to satisfy the vitamin C needs

A careful history may help to relate the onset of the eczema to the ingestion of a new food. If the food is one in which the mother overindulged during the latter months of pregnancy the infant may have been sensitized in utero. Particular questioning should be directed to excessive indulgence in eggs, and egg-containing foods, milk, wheat fish nuts, candles, fruit and vegetables.

Sensitization to foods may also take place via the breast milk Occasional feedings of raw milk during the neonatal period, raw foods taken during convalescence from disease, overfeeding, the too early introduction of solid foods, excessive indulgence in seasonal or bizarre foods, may all help to explain sensitization Questions along these lines may point to the incriminating food

Environment -Animals should be removed

All dust producing articles should be eliminated as far as possible, including stuffed toys. All pillows and mattresses that are retained should be covered with some impervious material, e.g., down-proof Egyptian cotton. The rubberized materials available on the market have a tendency to produce sweating, and in addition are very expensive. Fuzzy woolen garments, rough materials in general, and pure silk should be eliminated. Garments should be made of soft cotton materials.

Medication —Local medication must be aimed at healing the damaged skin and relieving the itching. The following are a few of the remedies I use, but ingenuity must be exercised in the choice and application in the individual case

(A) For secondarily infected wet, oozing skin I have found a 2 to 4 per cent aequeous solution of gentian violet an excellent compound. It should be used freely and frequently and can be aided in its drying affect by applying calamine lotion over it. Its healing properties are good, and at times it proves the most gratifying compound.

Calamine lotion, in single or double concentration, with phenol up to 3 per cent, or without it, may be used for every case as an adjuvant, aiding in drying the wet areas and in the relief of itching

Lotio alba is also of value when a thin application is desirable. An equal mixture of lotio alba and calamine lotion makes an excellent preparation, particularly for the face and intertrigenous parts, for erythema and sudamina

Wet dressings advocated by many dermatologists are not of as much value in infants and children as in adults. They may lead to unnecessary chilling of the body. The difficulty of applying them must also be considered.

(B) Ointments are useful for the healing of the irritated and dry crusted forms of eczema. For the most part, it is not necessary to use proprietary ointments. With a little application of thought the physician can devise appropriate medication for the particular dermatitis. If one consults the United States Dispensatory, he will find practically every ointment in common use and by a proper utilization of this information ointments can be created to fit the needs of the individual patient.

For example, phenol (1 to 3 per cent), valued because it allays itching, and crude tar (1 to 3 per cent), for its healing properties, are important ingredients in most ointments devised for the treatment of eczema

The basic ointments are zinc oxide (Ung Zinc Oxid) and rose water (Ung Aq Ros) Now, if one wishes to add a softening agent, one can use white ointment (Ung Alb) which contains lanolin, or one can use Aquaphor Ointment of coal tar (Ung Pic Carbon) or compound ointment of tar (Ung Pic Co) may also be prescribed

If the skin is impetiginous, or infected, ammoniated mercury ointment (Ung Hydrarg Ammon) should be prescribed

If the skin appears to be trichophytotic, or infected, one can prescribe Whitfield's ointment, ointment of benzoic and salicylic acid (Ung Acid Benz et Salicyl)

If one is dealing with a scabetic or other parasitic involvement, sulfur ointment (Ung Sulfur) is indicated

Another excellent preparation is ichthyol ointment (Ung Ichtham)

Instead of commercial cold cream, one can use rose water ointment (Ung Aq Ros) which has a cooling effect

Vanishing cream, which contains sodium stearate, is excellent because it is greaseless, and it is gaining in popularity as a base for compounding various ointments

Because of the toxicity of boric acid it is best not to use boric acid wet dressings or boric acid ointment for young infants

Various combinations of these standard pharmacopoeial ointments may be prescribed to fit the needs of the particular child's skin. The pharmacist has little difficulty in compounding them, and the obvious advantage is the small dosage of the individual ingredients when prescribed in such varied combinations.

If large areas are to be covered, it may be advisable to prescribe the basic ointments individually—that is ichthyol ointment, zinc oxide ointment, sulfur ointment, etc., as such—and the nurse or parent can experiment with them in equal or varying proportions (mixing with the aid of a tongue depressor) to discover what combination is most healing

These suggestions will take care of the majority of skin lesions

While the child is being treated with ointments, the body should be completely covered. At times complete restraint may be essential, the hands and legs being secured to the crib slats. In my experience I have not found that bathing with a bland soap and water is contraindicated. A soapless agent, such as Acidolate, may be of

value The removal of dried crusts is often admirably affected by the free use of hydrogen perovide and sterile cotton

Sedatives of greatest value are phenobarbital in small doees, e.g., 1/4 grain, and acctyl salicylic acid in 3 to 5 grain doees. A combination of both is often most effective.

If the child has a real retardation in bone age as determined by x ray of the wrists, the administration of thyroid in judicious quantity is indicated.

Unsaturated fatty acids, found particularly in lard, soybean and inseed oils have been advocated by some workers. Whether these are proved mentorious agents or not no harm can come from their addition to the diet, and some good may accrue. They should be used in con junction with the allergenically denatured diet.

Under no circumstance should an eczema case be vaccinated against smallpox, because a serious

or fatal consequence may result

The question about antibiotics will undoubtedly be raised. It is hazardous to use sulfona mides, penicillin, streptomycin and tyrothricin continents for the reason that in infantile eczema absorption may result in sensitization numerable cases have already been reported of marked skin sensitization, resulting from the use of one or other of these substances, with serious and at times a dangerous outcome. However, in a severe case of secondary infection these antiblotics should be used as they are in all severe infections, and they should be used intensively They should be given preferably by mouth or inlection. This does not condone the general Adminupromiscuous use so prevalent today tration in the absence of infection should be frowned upon

The so-called antihistamine drugs benadryl

pyribanzamina, and so on, while they do allay itching to some extent, do not control the itching of a severo case. They should be used circumspectly if they are employed and prescribed to be taken at night because of the marked effect of drowsiness which they produce in some cases, or of cerebral etimulation in other instances. As an adjuvant they are permissible. They do not in any sense correct the external

Conclusions

1 Infantile or childhood eczemas, as defined herein, whether they are initiated by intrinsic or extrinsic factors are viewed as an allergic dermatitis.

2 Of all the allergic syndromes, the age of

onset is earliest for infantile eczema

3 Eczema may be self limited and clear spontaneously without any residual sensitivity

4 Many allergic dermatidities however, are

5 Persistent cases should be studied thor oughly from an allergic standpoint and specific anti-allergic preventive measures instituted

6 The early eczema is often a pediatric problem and the salient features of its management

are detailed

7 In the management of eexema the best results are obtained if the case is viewed from the standpoint of diet, environment, psychosomatic and constitutional phases in conjunction with local dermal therapy

8 The use of local antibiotic therapy is not

approved as a routine measure

9 The antihistamine drugs are pallintive and do not correct the underlying pathology of allergic dermatitis

50 East 78th Street

OFFER FELLOWSHIPS FOR PUBLIC HEALTH DEGREE

Fellowships leading to a master's degree in public health are again being offered to any qualified United States citizen between the ages of 22 and 40 according to a statement released January 16 by the United States Public Health Service Federal Security Agency Funds are available through a grant from the National Foundation for Infantile Paralysis.

Candidates must hold a bachelor's degree from a recognized college or university at the time the application is filed, and must be able to meet the entrance

requirements of the accredited school of public health of their choice Proof of acceptance at such a school must be furnished before applications are submitted to the Pellowship Awards Committee for consideration.

In addition to the back-lor's degree courses in the biological sciences, sociology and education are required Training in public speaking, journalism, psychology and work in public health or a rolated field is considered desurable

AN IMPROVED DEVICE FOR EXTENSIVE ECG EXPLORATION OF THE CHEST

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THE use of multiple precordial leads is well Lestablished The number of placements is limited, as a rule, to 6, the electrodes $(V_1 \text{ to } V_6)$ are affixed to the anterior chest wall at the level of the fourth intercostal space and extend to the left midaxillary line 1 A switchbox has been utilized to facilitate taking these leads 2 Groedel explored the entire chest,3-5 Kisch and Richman employed 6 to 8 electrodes on each side of the chest and a central electrode over the midsternum 6 The value of placing electrodes high in the left axillary territory when lateral wall infarction is suspected was stressed by Wilson and his coworkers 7 Complete systematic ECG examination of the entire chest topography was still, however, an uncommon practice, chiefly because of technical difficulties The following device and procedure were developed to overcome these difficulties

- 1 A rubber harness is constructed of 4 horizontal rubber belts ($2.5 \times 100 \times 0.2$ cm) fastened by metal collar buttons to several vertical rubber strips ($2.5 \times 15 \times 0.2$ cm) The horizontal belts are held 1.5 cm and the vertical strips 8 cm apart. All rubber parts have perforations 2 mm in diameter and 9 mm apart. A small metal hook is attached to one end of each horizontal belt. Shoulder straps of the same rubber strips may be employed
- 2 Electrodes are made of brass with a flat disk 2×0.1 cm and a shaft 2 to 2.5×0.6 cm
- 3 Sponge rubber is trimmed to segments $2 \times 1.5 \times 1.5$ cm
- 4~ A switchbox, or several if required, $20~\times~30~\times~35~$ cm , has selector switches with dials on the upper panel, rows of sockets in the front panel for 80 chest leads, and 1 or 2 sockets for wires to the ECG machine
- 5 Connections are of insulated multiple strand copper wire, approximately 12 gage Each wire is 120 cm long with a banana plug soldered to one end and a small Mueller bulldog grasping clamp at the other end

The apparatus is assembled by inserting 20 electrodes in each of the 4 horizontal belts Around each circular chest level, the designated electrodes are placed as follows #1 lies over the midsternum, #6 over the left midsxillary line, #11 over the spine, #16 over the right midsxillary line Interposed between #1 and #6, #6 and #11, #11 and #16, #16 and #1 are 4 equidis-

tantly spaced electrodes Irregularities of chest contour are filled in at all levels by affixing a segment of sponge rubber to the shafts of electrodes #20, #1, #2, in contact, respectively, with right sternal border, midsternum, and left sternal border, and electrodes #12, #11, and #10, in contact, respectively, with right paravertebral, vertebral, and left paravertebral areas The shafts of these electrodes are pushed through perforations in the belts, the sponge rubber filling the space between electrode disk and rubber belt. The banana plugs, suitably numbered, are inserted into the correspondingly numbered sockets of the switchbox.

Procedure

The patient is seated on a round stool and the harness, mounted with 80 electrodes, secured around the chest The metal hook of each horizontal rubber belt is fastened to a perforation in the same belt at a point close to the right midaxillary line The electrode, sixth in series from the metal hook, lies over the midsternum and is designated #1, the successive electrodes are numbered 2 to 20 in rotation paste is delivered by a 10 cc glass syringe to the The Mueller undersurface of each electrode clamp of each numbered wire is attached to the shaft of a correspondingly numbered electrode The ECG machine is adjusted to standard lead 3 The cable of the left leg electrode is connected to the switchbox, and the cable of the left arm electrode to the left leg A record of 2 to 3 heartbeats is taken in rapid succession with each electrode The instomatic device of the standard ECG machine will enable the operator to secure 80 records in ten to fifteen minutes, covering 4 circumferential levels of the chest, thus providing a consecutive ECG record of the entire spherical cardiac surface A fifth series of electrodes may be applied at the ensiform level

About 100 cases were studied with this procedure. Fifty patients whose ages ranged from sixteen to sixty-two were normal, the rest were patients with hypertensive cardiovascular disease, rheumatic heart disease, and myocardial disease associated with arteriosclerotic changes.

Results

All the complexes in the normal subjects with vertical hearts, showing right axis deviation, were



Fig. 1. Rear view of rubber harness with electrodes in place and connected to 2 selector switchboxes, each accommodating 40 connections (a angle switchbox for 80 connections may be employed instead)

Upper right a single electrode with and without segment of rubber sponge.

Upper left side view of harness showing metal hooks.

apt to be inverted in all or most placements at circumferential level 1 and often at level 2 as well. The records resembled those taken with VR or esophageal leads. In advanced mitral disease with right axis deviation the ECG pleture was practically identical at levels 1 and 2 but at levels 3 and 4 the full inscription of the left ventricle made its first appearance as late as placement 8 or 10 or not at all. The record was dominated by QS, R appearing if at all, at the right axilla and right chest.

Normal subjects, many of whom had semi transverse or horizontal hearts, and most subjects with right axis deviation disclosed the following T pattern at levels 3 and 4 T was upright, but the voltage steadily declined from about placements 1 to 10 then T became negative, the voltage steadily rising from placements 11 to 20.

This was observed with CF but not with CR leads.

In contrast all 4 circumferential levels in left axis deviation with left ventricular hypertrophy associated with hypertension disclosed an opposite picture. The was negative in placements 1 to 10 approximately and became upright from 11 to 20. This was observed not only with CF but with CR, CL, and CW leads. Hypertensive cases unaccompanied by left ventricular hypertrophy showed the T pattern observed in the normal group.

Discussion

Records taken from right to left on the anterior chest often reveal a small R which enlarges across the transition zone i.e., the area in which the potentials of both ventricles are mixed. As the left side of the chest is approached, a full R is likely to appear, this is the insigne of the left Sometimes the R remains small or absent over the right side of the chest and across the transition zone as well, the left ventricle appearing suddenly, well on the left side tinuing around the back, the R wave of the left ventricle steadily dwindles and Q or QS may dominate the picture

It might be argued that since the R produced by the right ventricle is small in most cases, it follows that the mass of the right ventricle does not develop enough electromotive force to cause a The right ventricle, however, good-sized R should be expected to produce an effective R, because, although the thickness of the chamber seldom surpasses that of the left ventricle, it is, nevertheless, fairly thick. As a matter of fact, the R is of good size in about 25 to 30 per cent of cases in which the right ventricle is normal or It is also of good size in right hypertrophied bundle branch block where the impulse, arriving at the unblocked left ventricle, touches off this chamber, the impulse then reaches the right ventricle from which a very effective R wave arises, since this chamber remained unaffected by the potentials of the left ventricle

The R wave obtained in the cavity of the right ventricle, on the other hand, is often small 8 We may, therefore, infer that the R wave is already small before the right ventricular mass gets

into action and that the smallness of this wave is not a reflection of a small amount of electromotive force developed by the ventricular mass The wave is small because its excursion is cut short by the powerful potential of the left ven-The negative deflection (QS complex), often observed in such circumstances, is due to the potential of the left ventricle travelling away from the precordial electrode

Conclusion

- 1 A simplified, efficient device and technic have been developed for securing 80 or more chest lead
- 2 ECG findings obtained by this method have been briefly discussed

1020 PARK AVENUE

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PLAN PROGRAM FOR LEPROSY RESEARCH

The Advisory Medical Board of the Leonard Wood Memorial and a group of consulting chemotherapists, nominated by the chairman of the medical division of the National Research Council, recently met in New York City, for the purpose of planning a program for extensive research to find improved drugs or methods for treating leprosy

This meeting was probably the first at which a large group of distinguished scientists, most of whom were not leprologists, has met to consider this health problem from the strictly scientific viewpoint

There was general approval of two plans One is to establish a cooperative scheme with selected workers in various countries, under a central coordinating committee, whereby the new drugs now in use may be evaluated scientifically, by uniform methods of procedure and recording. Another is to establish, in connection with some suitable leprosy institution, a testing unit with special personnel to make preliminary tests of new drugs which appear to be of promise, but which have not yet been used in the treatment of leprosy

HIATUS HERNIA CONFUSED WITH CORONARY THROMBOSIS

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THERE are many patients whose chief com-plaint is pain in the left chest. The cause is often considered to be coronary insufficiency with myocardial damage If an electrocardiogram is done and evidence of myocardial damage is found, the patient is condemned as a cardiac case, and no further search for the cause of pain is made. At times the diagnosis of coronary throm bods is adhered to despite the lack of confirming evidence. Because of the serious prognostic im plication in the diagnosis of angina pectoris or coronary thrombosis, it is essential to emphasize one of the sources of diagnostic errors, namely histus or diaphragmatic hernia. It has often been demonstrated that gastrointestinal disease may amulate cardiac ailments. Wakefield in discussing gallbladder discase as related to cardiac disease, mentions a sixty year-old white woman, who gave a perfect history of acute coronary thrombosis, but because of the lack of confirmatory evidence gallbladder and gastrointestinal x ray series were done and revealed an esophageal hiatus hernin.1 One must remember, however that heatus herma and coronary occlu sion may coexist Widmer states that herma of the abdominal contents into the thorax may take place through any natural opening in the diaphragm which has weakened or dilated ' He further states that sixty per cent of these are through the esophageal opening

There is a definite anatomic and physiologic relationship between the cardiovascular and gastrointestunal systems. Both are innervated by the sympathetic and parasympathetic nervous systems and are subject to reflexes in either of these systems. According to Head's work, pain from the heart is referred to the third and fifth cervical segments, and the seventh and eighth dorsal segments, predominantly on the left side but sometimes bilaterally: Pain from the stomach is referred to the seventh, eighth, and amth dorsal segments, bilaterally This explains why pain from either stomach or heart may be referred to the substernal and epigastric areas and to the neck and left clavicular regions. Pain due to disturbance in the diaphragm heart esophagus, and stomach, is carried over the Visceral afferent nerves, and results in so-called viscerocutaneous or referred, pain. ments involved are the ones described above. However, the stimuli may be spread to several levels above and below the original levels of **s**timulation

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The painful stimuli in hiatus hornia may be due to irritation of the hernia wall itself or to that of the marginal portion of the histus in the dia nbraem There may even be some painful stimuli referred from the terminal end of the esophagus. Not only may irritation of these three areas cause pain, but they may also cause various arrhythmias. If the work of such observers as Gilbert, Fenn, LeRoy, and Green is to be accepted, irritation or distention of the areas mentioned may even cause a reflex vasoconstruction of the coronary arteries 7 This is supposed to occur as a result of a reflex, set up by the stimula tion of the vagus nerves in the stomach and esophagus.

Many patients with diaphragmatic hernias frequently go through life without being aware that anything is amiss. Symptoms occur when a restricted portion of the stomach or other abdominal viscera are caught in one of the small openings in the diaphragm. The symptoms are more often related to the gastrointestinal tract with acute pain, vomiting, or dysphagia. Occasionally, the symptoms are referred to the cardiac region and are difficult to explain, unless the real cause is found Physical signs are rarely present, unless the part of the viscus herniated is large and contains air or fluid Most frequently, the diag nosis is made on suspicion and confirmed by x-ray study This is particularly true in a patient with cardiac pain but in whom there is no confirmatory evidence of myocardial disease such as lack of progressive changes in serial electrocardiograms. elevated sedimentation rate, leukocytosis, or temperature rise.

The patient a story may be typical of an acute coronary thrombods, including severe pain in the left chest sensation of choking and pressure and even radiation of pain to the left neck and shoul der areas. In addition to the above symptoms. the patient complains of a good deal of eructation and does not have the feeling of impending death Until the diagnosis of higtus hernia is established. the patients are treated as a case of coronary thrombosis However efforts to keep patients quiet and at bed rest are in vain. They claim that they are more comfortable in an erect position Ingestion of food makes them more uncomfortable if they eat or rest while in a horizontal or semi horizontal position Being up and around after a meal gives them more comfort particularly if they are able to belch. Within a short period of time I had the opportunity of seeing three

patients whose chief complaints were related to the chest and who were diagnosed as having myocardial disease due to coronary occlusion

Case Reports

Case 1 —H O, a forty-nine-year-old white man, was an electrical contractor On January 8, 1945, while installing some x-ray equipment, he was seized with an attack of pain, in the substernal area, which radiated to the neck and both arms He also complained of choking sensation and palpitation Associated with this there was a good deal of eructa-Blood pressure at this time was supposed to have been 100/70 An electrocardiogram revealed minimal changes, suggestive of myocardial damage (Fig 1) The patient was told that he probably had a coronary thrombosis and was advised to go to bed On January 28, the electrocardiogram was repeated, and it was thought to show some prolongation of the QRS in L₂ However, close study showed this to be well within the normal range

On February 27, 1945, I saw the patient for the first time With the previous history in mind, I accepted the diagnosis of coronary thrombosis and repeated the electrocardiogram which showed no further changes except for a few extrasystoles. Sedimentation rate was 9 mm in one hour White blood count was 7,900 with polymorphonuclears 68 per cent, lymphocytes 30 per cent, eosinophils 1 per cent, and monocytes 1 per cent Blood pressure was 138/80 I ordered the patient to bed, and the usual cardiac regime was instituted This consisted of a bland, low gas-forming diet, and medication containing papavarine hydrochloride, atropine sulfate, phenobarbital, and aminophyllin The patient seemed to improve somewhat

On April 9, 1945, the patient again complained of severe epigastric and substernal pain radiating to the neck and arms, choking, and palpitation Blood pressure was 130/78 An electrocardiogram repeated at this time showed no change Sedimentation rate was again 9 mm in one hour patient was still treated as a possible case of coronary thrombosis, despite the fact that during all this time there was no temperature rise, and the blood pressure varied from 138/78 to 146/92 The outstanding complaint between attacks of pain was eructation, and the patient claimed that he felt better in an upright position, having at times gotten out of the bed against orders, because he felt better when up and around An electrocardiogram on May 5, 1945, still failed to show any evidence of progressive myocardial changes At this time, I felt that another cause for his complaints should be sought and advised gallbladder and gastrointestinal studies with the possibility of hiatus hernia in mind The gallbladder series was negative, and the gastrointestinal series was reported as negative, except for a redundant large bowel The patient was continued on a bland, low gas-forming diet with antispasmotics (bellandonal), but he still complained of vague epigastric pain and belching On May 21, 1945, the gastrointestinal series was repeated and this time revealed a hiatus hernia (Fig. 1)



Frg 1

then, this patient has been reassured that there is no evidence of coronary thrombosis and has been kept on similar diet and medication. He has been instructed not to eat large meals, nor drink fluids with his meals. When he adheres to this regime, he feels comfortable, and there are no further episodes of severe substernal pain.

Case 2 -A physician, H L, in 1937, at the age of thirty, while serving his residency, experienced a severe attack of epigastric and substernal pain, with a desire to belch but could not Neither alkalı nor food gave relief The patient passed a stomach tube himself, which resulted in expulsion of gas and fluid material and gave him complete relief for one year In 1938, he began to have attacks of precordial pain, related to walking and radiating down to the biceps areas of both arms These were typical of attacks of angina pectoris, and, if they occurred with activity, they were relieved by rest. Emotional excitement also caused these attacks In addition, he noticed that there was a good deal of eructation and that he felt better when he was up and around than when lying down These attacks subsided completely without any definite therapy

He was well until 1941, when, while driving his car, he developed in his left chest a very severe constricting pain which radiated to both arms. Associated with this was a marked desire to belch. He was sure that he had an attack of coronary occlusion.

but noted that there was no feeling of impending death. He drove home and was given morphine sulfate, 1/4 grain, which relieved him completely An electrocardiogram taken in the sitting position was negative This was repeated the next day and showed in inverted T: It was thought that he had had an acute coronary thrombosis and he was kept in bed for six weeks, despite the fact that he felt well showed no drop in blood pressure no temperature rise, a normal sedimentation rate, and normal white blood count. At the end of six weeks the only change in the electrocardiogram was reversion of the Ti wave to upright. During his six weeks in bed he was greatly troubled by the feeling of distention and cructation. At the end of the six week period he felt so well that he resumed full physical activities returning to a full and active medical practice.

He remained well until August 1944 when he again began having similar attacks of angina pectors. Associated with his chest pains, there was marked belching, and the feeling of abdominal distention. Because of his previous episodes another cause for his symptoms was sought Gallbladder eries was negative. An electrocardiogram (Fig 2) done in August, 1944 in the upright position showed flat T in L-1 low voltage of the QS complex in L-2 and an inverted QRS and T in L-4 There was also an apparent left axis deviation and strain mentation rate was 11 mm, in one hour blood count was 7 900 with a normal differential These remained the same from then until the present. At no time was there a rise in temperature X-rays of his chest showed that the left dome of his disphragm was as high as the right, causing an apparent enlargement in the transverse diameter of Serial electrocardiograms showed no further changes, except that the once taken in the borizontal positions showed an inverted T₁ (Fig. 2) while those taken in a sitting position showed a low to isoelectric Tr

At this time it was felt that the patient did not have a coronary occlusion because of the marked eruciation and relief in the upright position A hiatas herma was suspected and confirmed by gastrointestinal x-ray studies (Fig. 3)

It is interesting to note that when he had an

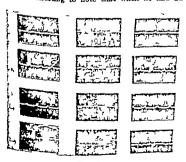


Fig 2.



Tro 3

attack of severe chest pain there was distention of the upper abdomen and protrusion of the left anterior chest wall. There was loss of hair over this area, which may have been caused by increased pressure on the inner surface of the anterior chest wall. interfering with the intercostal vessels and nerves which supply the nutrition to that area. The electrographic changes which simulated that of an terior wall damage may be due to the tamponade action of hernia, causing the anterior surface of the heart to press against the anterior chest wall with actual damage to the myocardium from this pressure. Or the changes may be due to torsion and rotation of the heart. The electrocardiographic changes might also be explained by the vasoconstriction reflex, via the vagus nerve resulting in coronary ischemia, as previously described

On a regime similar to that of the first patient plus changing of the intestinal flora by the addition of acidophilous milk and milk sugar to the diet, the patient is leading an unrestricted professional and social life

Case 3—Y F a sixty-nine-year-old white woman was admitted to Morrisania City Hospita in March 1946 because of rheumatoid arthritis and vague obdominal complaints. While in the ward, she developed an attack of severe constructing pain in the left chest, radiating to the neck and left arm. Along with this there was a great deal of cructation and the patient stated that she felt better in an upright position

An electrocardiogram was negative. At this time



Fig 4.

the case was diagnosed as coronary occlusion However, because of lack of confirmatory electrocardiographic findings and a normal sedimentation rate, and normal white blood count, gallbladder and gastrointestinal x-ray studies were made to seek another cause for her chest pain Gastrointestinal series in April, 1946, revealed a small hiatus hernia (Fig 4)

Summary

Three cases of hiatus hernia, which were originally diagnosed as coronary thrombosis, are presented to demonstrate that histus herma may mimic angina pectoris and coronary thrombosis It is because of the serious prognostic outlook in the diagnosis of coronary thrombosis or angina pectons, that the true cause for chest pain must be ascertained The diagnosis of histus herma can be confirmed with comparative ease, once it is suspected

An attempt is made to explain the cause of pain in hiatus hernia similar to that of coronary The pain of thrombosis or angina pectoris hiatus hernia is probably initiated over the

visceral afferent fibers supplying the esophagus and cardiac portion of the stomach, or, over the sensory afferent fibers from the diaphragm, contained in the phrenic, or middle or lower thoracic nerves, and, thus, is referred to the same segments as cardiac pain. Thus, overdistention or irritation of the hermated portion of the stomach may be responsible for the production of the anginal or coronary type of pain

The second case reported is of special interest, because of the area denuded of hair and the changes in the electrocardiogram. An attempt to explain these changes has been made in the discussion of the case The varying T1 may be explained by torsion or by actual myocardial damage, caused by tamponade of the herma with pressure myocarditis or by the vasoconstriction Although the patient did not act as a true coronary thrombosis, there is always a possibility that it may have coexisted

When surgery is contra-indicated or refused, it may be worthwhile to attempt to allay gastric distention by changing the intestinal flora, thereby decreasing the amount of fermentation

It is important to remember that the anginalike pain of hiatus hernia is more apt to be associated with eating than with effort. The patient usually complains of a good deal of eructation and feels better when he is up and around It is important to bear in mind that when a patient has symptoms of angina pectoris and coronary thrombosis, but stresses the facts just mentioned and fails to show confirmatory evidence of coronary disease, other causes for his complaints must be sought, among these, hiatus hernia should always be considered

2021 GRAND CONCOURSE

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PUBLISH NEW MAGAZINE FOR DIABETICS

On December 12 a national magazine for diabetics and the general public was launched by the American Diabetes Association, which is publishing the new periodical, called A.D.A Forccast Its publication is made possible chiefly through a three-year grant by an interested family to the American Diabetes Association.

A D A Forecast will contain articles by authorities on diabetes, but presented in language suited to nonmedical readers, its contests will also include infor-mation on diet, inspirational articles, question and answer columns, and news of progress in the control The magazine will also disseminate of diabetes facts on prevention of diabetes.

UVEITIS OF UNDETERMINED ORIGIN, WITH CERTAIN ETIOLOGIC CONSIDERATIONS*

JAMES A. INCIARDI, M.D., F.A.C.S., Brooklyn, New York

HEREWITH is reported a case of uveitis which occurred under a somewhat unusual set of cir cumstances. The peculiar background not only made this case something of a medical emergency but also introduced problems regarding etlology and decision as to therapeutic approach

Case Report

F G., a 37 year-old white man, came to the office on May 9 1946, complaining that his left eye had been 'inflamed and irritated' for the preceding six months and that more recently there had been slight blurring of vision. This was his only seeing eye. The right eye had been struck by a snowball twenty fire years before. Vision was reduced considerably in this injured eye after the accident but five years ago it had blacked out altogether. The only other past history of possible significance is the fact that he had had a severe cold ten days before I first saw him.

Examination.—Tension was 25 mm (Schiotz) in a right eye and 13 mm. in the left. The right, or the right eye and 13 mm. in the left. noncenng, eye revealed a 15-degree divergence, a mature, cataractous, subluxated lens, an atrophic hm, and light perception only with poor projection in the left eye there were a moderate number of grayla-white, small, round, posterior corneal depoits, fairly uniformly distributed. Slight aqueous intro was present, and there were some dust-like depoits. posits on the anternor lens surface. Moderate-sixed opacities floated in the anterior vitreous, and the tundos showed changes of high myopia. A weak 20/40 was obtainable with—10 00 S - 2.50 C × 140

The patient was admitted to the Brooklyn Eye

and Ear Hospital for work-up to determine etiology

and for observation and treatment.

Several blood counts urinalyses, sedimentation tests, and blood chemistries were normal. General physical examination, urologic survey chest plate, payaca examination, urologic survey cases prace, and dental check, including x-rays, revealed no abnormality Arguitanation tests for brucellosis, Mantoux tests, Rahn, gonorrhea complement first tion tests protein sears, and stools were negative. Three different field studies of the left eye were within newest little and togeneous testings. within normal limits, and tonometric testings throughout the month of hospitalisation were the same as the original readings. To rule out sar-coidosis, radiologic studies of the hands and feet were made and albumin-globulin ratios determined These were normal. There was 3 plus involvement of the left antrum and a large amount of fluid pus was expressed from the left tonsil.

Because of the history of injury twenty five years previously, further deterioration in vision five years before additional of dislocated before admission, with the findings of dislocated cataractors less and an almost totally blind right ere the problems of lens protein sensitivity and sympathetic ophthalmia, though possibly far fetched, were also considered. The bones of the orbit were radiographically negative and no opaque foreign body was demonstrable. Skin tosts with bans protein stabilizations toring and uves pith the sympathetic stabilizations toring and uvest pig kens protein, staphylococcus toxin and uveal pig

ment were made These showed slightly positive reactions in twenty-four and forty-eight hours Eleven days after the skin tests a full thickness section of skin containing the area injected with uveal pigment was excised from the arm. By microscopic study of this section Dr J Arnold de Veer demon-

strated a slightly positive reaction.

Treatment—Penicillin was administered intra muscularly for the first two weeks. At the end of this time a tonsillectomy was performed and the left antrum opened The patient also was given six courses of intravenous typhoid therapy boiled milk intramuscularly salicylates by mouth, and atropine

and heat locally

Course -The first week in the hospital produced no noticeable change in the eye condition. In the second week the corneal deposits in the left eye increased in number. In the third week a few dustlike opacities were seen for the first time on the posterior cornes of the right eye. The deposits in the left eye did not increase and a few of them became slightly brownish in color There was no keratic precipitate increase in the fourth week and a greater number of the deposits in the left eye became brownish. By the time the patient was discharged from the hospital corrected vision in the left eye had improved from 20/40 to 20/30

Since the patient s discharge there has been a very ow but steady improvement. The dust-like opaci slow but steady improvement. ties in the right eye slowly disappeared. The deposits in the left eye gradually became thinner and fewer. The only after-discharge treatment has been the occasional use of atropine and a two-month rest. One year after the original visit the right comes was The left cornea showed about one half the original number of deposits. These were thin brown, and had a dried out appearance. Vision was 20/25 with -9 50 S -2.50 C × 145

Comment

The progress of the disease while the patient was under intensive treatment was such that it would be difficult to relegate the improvement to any one form of treatment. There was no clear-cut flare-up or decrease in pathology with any one procedure. The only possible therapeutic relationship was the appearance of deposits for the first time in the right eye after the tonsil and sinus surgery and one can not be sure but that this may have occurred without the surgical intervention. Dr Walter V Moore. who saw this case in consultation, concurred with the procedure followed and was of the opinion that there may have been a relationship. Dr. Bernard Samuels, after examining the patient suggested the possibility of a low-grade tuberculous lesion, probably in the flat part of the ciliary body His ex perience has been that these cases do well with complate rest for several months 1

It is conceded that sympathetic ophthalmia is rare without rupture of the globe that the interval between injury and onset is a short one, and that the exciting eye usually shows a persistent low-grade uveitis, with periodic painful exacerbations iris

^{*} Presented before the Brooklyn Ophthalmological Society April 17, 1947

nodules, and a tendency to phthisis bulbi 2 However, there have been published cases where sympathetic disease has been reported without perforation 34 As to time intervals, Fuchs, 5 Weeks, 6 and Knapp' reported cases having their onset as late as twenty, forty-two, and forty-five years, respectively Duke Elder states that sympathetic ophthalmia may follow almost any type of condition, even a clean wound that has apparently healed rapidly and without complications? For these reasons it was felt necessary to include sympathetic ophthalmia in the investigations

Nongranulomatous disease of the anterior uvea is usually acute, with slight iris but marked ciliary reaction, and with no nodule or synechia formation 8 The evudation, being lymphocytic, manifests itself in small, pinpoint corneal deposits, and the eyes recover with few residua This type is believed to be The granulomatous type has a infective in nature more insidious onset, ciliary reaction is slight, and organic changes occur in the iris, with nodule and synechia formation. The evudation, being episynechia formation theliod, manifests itself in mutton-fat corneal deposits, and more or less ocular destruction occurs The recognized causes for this type are syphilis. tuberculosis, lymphogranuloma venereum, fungus infections, sarcoid, and brucellosis In a few cases in which differentiation is difficult, characteristics of both types appear in the same eye

The case under consideration, although apparently manifesting signs of both types, seemed to fall chiefly into the nongranulomatous category most frequent positive findings in this class are rheumatoid arthritis, old gonococcal infection, a

small active focus, or a recent acute infection of some This patient had had a recent cold, and investigation also uncovered infected tonsils and sinuses Since complete work-up eliminated all possible causes of nongranulomatous and granulomatous uveitis except the upper respiratory tract, the logical line of reasoning would lead one to accuse this organ

A case of this type always brings up the subject of hypersensitivity to bacterial protein If organisms of low virulence or in small numbers invade the eve. they can be destroyed by the normal bacteriocidal action of the ocular fluids, but this primary invasion may produce local hypersensitivity to bacterial pro-When the bacterial antigens again reach the eve, through reinfection or absorption from an infected focus, a hypersensitive reaction results Experimental production of such a state has resulted in a nonpurulent ocular reaction similar to the case which came under my observation If this is so, the patient, having had the only possible reactivating foci eliminated, should be more permanently benefited than he might have been by desensitization

149 Midwood Street

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SIX REGIONAL HEALTH OFFICES PLANNED FOR STATE

The State Department of Health plans to establish by February 1, 1948, five upstate regions with offices located in Buffalo, Rochester, Syracuse, Albany, and New York City, and a sixth region, with head-quarters also in New York City, to serve the metropolitan area The plan was announced by Dr Herman E Hilleboe, state commissioner of health, in an address, "Planning for Health in the State of New York," which he presented at the Seventy-Fifth Annual Meeting of the State Charities Aid Asso-ciation at the Waldorf-Astoria Hotel, New York City, on December 8, 1947

Explaining the purposes of the proposed offices, Doctor Hilleboe pointed out that the expansion of health services in the modern world suggests a regrouping of the traditional activities of local health departments to permit an enlarged scope of program and the application of multiple technics that will bring improved health and services to the people To reach this important goal, local health services should be directed toward three specific objectives

Prevention and control of mass diseases, including maternal and infant hygiene

- Collection and analysis of vital records, including analysis of morbidity and mortality of the principal killers
- Maintenance and improvement of a healthy environment This includes a continuation of safeguarding food and water supplies, sewage disposal, good housing and the maintenance of healthy environment for recreation and labor

The proposed regional offices will carry these technics into effect. They will provide consultation service to the staff of the district, county, and city health departments within the region, assistance in program planning, development, and operation, guidance to local health departments and observations, for the State Department of Health, of the local health departments located within the region

No direct services to local residents will be given by any of the personnel assigned to these regional offices except in the unorganized district on a temporary basis until permanent plans have been made —Health News, December 22, 1947

A FOREIGN BODY FATALITY

CHARLES C WOLCOTT, M D , Bronxville, New York

(From the Grasslands Hospital)

THE presence of a foreign body in the air or food passages of the body may offer adifficult diagnostic problem. Even an opaque foreign body may be rendered nonopaque by an inflammatory condition. A nonopaque substance may disclose its presence by producing an obstructive emphysema if it prevents the escape of air on expiration or an atelectasis if it prevents the by passage of air on inspiration it is imperative that reentgen examination be made at the beginning and end of respiration. A foreign body must be suspected if a wheere is heard. This wheere may be best heard at the open mouth. Also

In a child who has acquired a foreign body with anyone's knowledge the problem becomes more difficult. This is especially true of esophageal cases. The case herein reported illustrates this situation in

a very dramatic and tragic manner

Care Report

An eleven-month-old child swallowed a large, open safety pin without anyone a knowledge. For the first lew days he presented a progressive anorexia and irritability. His symptoms were not specifically indicative. On the third day emesis developed, followed by refusal of food and a moderate rise in temperature. Early in the morning of the fourth day he became seriously ill with chills, emesis, and supor. The family physician made a diagnosis of precumonla and congenital heart disease.

A reenigen ray examination revealed a large open safety pin in the lower cooplagus with point to the left, and an enormous cardiac shadow the heart occupying most of the left thorax. The patient was admitted to Grassiands Hospital in a moribund state with temperature of 103 4 F. He was given adrenalin, an infusion of 250 cc. of 5 per cent glucose in normal saline 1 Gm. sulfadiasine intravenously and placed in an ovygen tent. His condition improved rapidly and one hour later a clysis of 400 cc. normal saline was started. Two hours later 200 cc. of whole blood was given. This was followed by marked improvement. An esophagoscopy was performed, but the safety pin was not in the esophagus by this time. An area on the left wall adjacent to the heart was swollen and covered with granulations granifying that the pin had been in sile several days Despite intensive indicated therapy the child expired the following morning.

the following morning.

An autopsy was performed a summary of which follows

The pericardial cavity was distended, measuring 7 cm, in its major diameter It contained 150 cc. of coudy gray fluid and many fibrin clots. Both visceral and parietal perseardia were covered by a heavy shaggy grayish, fibrinous membrane. In the interior aspect of the pericardium where it is attached to the posterior mediastnum, a 0.5 cm, laccration, alightly reddened about its edges could be seen. A track could be traced through the abherent mediastinal connective tissue to the cooph agus at its junction with the cardia of the stomach.



Fig. 1 Pericarditis from puncture of pericardium by safety pin in esophagus.

In the right anterolateral wall of the esophagus there were two lacerated areas which extended through the thickness of the wall. One, about 1 cm. long was situated 1 cm. above the cardial opening, the other smaller one lay directly above the first, about 0.5 cm. distant. Both showed reddened and alightly edematous edges. These lacerations correspond to the position of the safety pin as visualized in the x-ray and undoubtedly demonstrate that the pin perforated the copinagus in two places penetrated through the incidiatinum and into the pericardial sac.

The right pleural cavity contained 75 cc. of cloudy

Interignit pictural cavity contained a control fluid, the left about the same. The peritoneal cavity contained a small amount of thin fluid. Aside from the fibrinous pericarditis the heart was remarkable only for its contracted state and rather pallid about the property of the property

Both lungs were atelectatic containing only seat tered crepitant areas. Both were moderately congested. The coophagus, as described, contained a few streaks of fresh blood locally. The stomach was dilated, contained gas and a brownish gray fluid, apparently with occult blood. Just beyond the pyloric spinieter the duodenum was stretched over a 3 cm. ordinary open safety pm, orientated with the closed end distally the point and head toward the stomach. There was some local laceration and the nuccess was strenked with blood. No ponetration of the bowel was noted. Much of the small bowel and all of the large bowel was distended with gas its wall pale and of purchment thinness and transparency. Peyor's patches and mesenteric lymph nodes were readily seen but not much enlarged.

Cultures were taken of heart's blood and pencar-

dial exudate

Gross Findings —Fibrinopurulent pericarditis, traumatic laceration of the lower esophagus by a safety pin with penetration into the pericardial sac, traumatic laceration of the duodenum, safety pin in situ, pulmonary atelectasis, bilateral, pleural effusion, bilateral, and marked ileus of the stomach, small and large bowels

Microscopic Examination—Study of the tissue sections verified the gross diagnosis and added nothing of fresh diagnostic import

Staphylococcus aureus was obtained from both the postmortem blood culture and the culture of

the pericardial fluid

This case illustrates the necessity of early roentgen study in all illnesses of obscure etiology which present themselves

CIVILIAN DOCTORS MAY GET NAVY COMMISSIONS

The statutory authority contained in the Army-Navy-Public Health Service Medical Officer Procurement Act of 1947 makes it possible now for civilian doctors to become commissioned officers in the regular Navy, provided they meet the professional and physical qualifications. This law is unique in that it does away with, for the first time, the age limitation of 32 years, and permits doctors in civilian practice to enter the Navy and be commissioned with the rank up to and including captain. The law considers all strata of the medical profession, interns, residents, reserves, former medical officers who have resigned, and present practicing physicians.

In order to make application, a doctor must be a citizen of the United States, a graduate from a Class "A" medical school, and have served at least one year's internship in an approved hospital. Candidates will then be judged on a number of qualifications, such as being a member of a specialty board, his teaching connections, number of years of professional or scientific practice, hospital or laboratory connections, a statement of military service, and others

Doctors interested should write to the Bureau of Naval Personnel, via the Bureau of Medicine and Surgery, Navy Department, Washington, D C

US DEATH RATES

The year 1946 marks a new record low for the crude death rate in the United States, according to figures of the National Office of Vital Statistics recently released. The death rate for the year was 100 per 1,000 population as compared with the rate of 10 6 for 1945 and the previous lowest rate of 10 4 in 1942. The total number of deaths in 1946 was 1,395,617 or 6,102 fewer than in 1945.

The estimated death rate for the United States in 1947, based on data for the first ten months of the

vear, was 10 1

All figures are for the continental United States

and exclude armed forces overseas

During 1946 deaths from diseases of the heart increased for the third consecutive year. There were 429,230 deaths from heart diseases, or 4,902 more than in 1945, and 11,168 more than in 1944. This cause alone accounted for 30 8 per cent of the total number of deaths in 1946 as compared with 30 3 per cent in 1945 and 29 6 per cent in 1944.

Cancer and other malignant tumors continued to increase in importance as a cause of death. This disease caused 182,005 deaths or 13 0 per cent of the

total number of deaths in 1946

The number of deaths from the other major chronic diseases decreased from those for the previous year. There were 125,646 deaths from intracranial lesions of vascular origin in 1946 as compared with 129,144 in 1945, 81,701 deaths from nephritis

as compared with 88,078 in 1945, and 34,731 deaths from diabetes mellitus as compared with

35,160 in 1945

In 1946 as in 1945 new record lows were set for deaths from the major infectious diseases—pneumonia and influenza, and tuberculosis. The total of 62,234 deaths from pneumonia and influenza was 6,062 or 8 9 per cent fewer than the total of 68,386 in 1945. Tuberculosis caused 50,911 deaths in 1946, 2,005 or 3 8 per cent fewer than the total of 52,916 in 1945.

Maternal mortality also declined to a new low in 1946 Despite the tremendous increase in the birth rate, maternal deaths decreased from 5,668 in 1945 to 5,153 in 1946 From 1945 to 1946, the number of births increased approximately 20 per cent, while the number of deaths resulting from diseases of pregnancy, childbirth, and the puerperium decreased 9 1 per cent

Ninety-eight thousand thirty-three deaths from accidents occurred in 1946, 33,411 as a result of motor vehicle accidents and 64,622 from other accidents. The number of accidental deaths in the United States increased by 2,115 from 95,918 in 1945. This was due entirely to the large increase of 5,335, or 190 per cent, in deaths resulting from motor vehicle accidents.

Other types of accidents caused 3,220 fewer deaths

ın 1946 than ın 1945

ABSTRACT OF MINUTES OF THE COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

ATITS meeting on December 11 1947 the Council considered various matters, taking action or directing further study and reports as indicated under the following headings

Secretary & Report

Remassion of State Assessments —Remission of State assessments was voted on account of service with the armed forces for 397 members for 1947 and 68 for 1946, also on account of illness for Drs.
William M Findley, Rudolph D Orth Bernard B
Schnapper and H. F Strongin. The refunding of dues for two members was authorized

Nominations for Affiliate Fellowship in A.M.A.— The following retired members were nominated for

Affiliate Fellowship in A.M.A.

Herbert Richard Charlton Raymond Clark, John A. Conway George P Coopernail, Nathan W Greene, Jacob Heller William H Dodge, H Lyman Hooker, Frederick L. Keays Earl H. Mayne, Joseph Day Olin, William A. Randel, Charles Hich, Henry Schumer, James S. Slavin, William G Sprague, Harold Stearns Vaughn, Augustus B Wadsworth Ceorge Barclay Wallace, and Herbert Budington Wilcox Wilcox.

Meetings -The week following your last meeting it was my privilege to attend two delicious dinors and to hear interesting speeches. First at the one hundred and fiftleth anniversary dinner of the Westchester County Medical Society at the Wal dorf Astoria, and the second at a dinner given by the United Medical Service Inc. and the Associated

Hospital Service.

On November 20 your Secretary attended the Middle Atlantic States Conference of the American Medical Association Council on Medical Service, Along with Drs. Louis H. Baner, Thomas A. Mo-Goldrick, and J. Stanley Kenney and Mr. George P. Farrell. Dr. Frederick E. Lane, a member of our Society connected with the U.S. Veterans Administration, was also present. An outstanding presents tion on the program was made by Dr Bauer entitled "What Can We Do About the Practice of Medicine Within the Hospitals?

Your Secretary has also attended various committee meeting, including the first meeting of the new Subcommittee on Nutrition of the Public Health and Education Committee In Albany on November 28 Health Commissioner Hilleboo and other members of his department met with this com-

mittea

NY State Institute of Applied Arts and Sciences -A request has come from the New York State Institute of Applied Arts and Sciences for nomination of a member of their Advisory Commission. This Com mission consists of representatives of various pro-fessions and businesses and will assist in establishing courses of technical training, such as for medical secretaries.

After discussion, it was soled to table the request for a month in order to obtain more information

Request for Subcommittee on Accident Prevention.—
Request for Subcommittee on Accident Prevention.—
We vork State Health Commissioner Herman E.
Illieboe has requested that a subcommittee be
appointed on accident prevention. It has occurred
to me the commissioner than the contract the to me that perhaps you might like to increase the name and scope of your Subcommittee on Industrial Health Health, of the Committee on Public Health and Education, to include this function. That Sub-

committee consists of Dr Leon H. Griggs Syra cuse, chairman, Dr David J Kalaski New York, Dr Stuart A Good, Buffalo, Dr Leonard Green-burg New York, and Dr Stanley E. Alderson, Albany

After discussion it was rotal that the Subcommittee on Industrial Health be also designated as the Subcommittee on Accident Prevention with the possibility of nominating two or three additional men to it.

Communications.—1 Letter from Dr Harold A. Solomon chairman, Cancer Communitee, Dental Society of the State of New York, dated November 18, 1947, offering to cooperate with our Cancer Committee

After discussion at was voted that someone be designated from the Dental Society to serve on the Subcommittee on Cancer and that the president of the Dental Society be asked to make the designation

Letter from Dr John J Bourke, under date of December 1 1947 requesting nomination to fill vacancy left by the death of Dr F Leelie Sullivan, on the State Advisory Council to the Joint Hospital Survey and Planning Commission representing upstate medical interests.

It was noted that Dr O W H. Mitchell be nomi nated to fill the vacancy

3 Letter from Mr Royal W Ryan executive vice-president, New York Convention and Visitors Bureau Inc., dated December 21 1947, requestion that the Medical Society of the State of New York extend to the American Medical Association an invitation to hold their interim session in New York, in 1949 or 1950

After discussion, 11 was roted to extend the invita tion, but that it not be sent until after the January meeting of the House of Delegates of the A.M.A unless, in the opinion of the delegates attending that meeting, it seems advisable to introduce it at any time.

4 Letter from Dr Norman S Moore of Cornell University Ithaca, under date of December 8, 1947 regarding a letter from Dr Mary B Spatr protesting a resolution of the House of Delegates requiring the submission for censorship of articles written for the

This came up at the preceding meeting of the Council and it was voted that an editorial—it was on the question of writing an editorial-be withheld, and that the Council be requested to submit to the House of Delegates the question of the advisability of continuing this part of the Principles of Profes-

sional Conduct.

After discussion, it was roted that the Council rescind the action that was taken at the last meeting and make a statement that in the opinion of the Council, which is also the opinion of the Counsel of the Bocrety this particular part of Section 31-b may involve infringement of the constitutional right of free speech, and to refer it back to the House of Delegates with the recommendation that it be rescinded, and that an article replace it in the Princi ples of Professional Conduct to the effect that mem here who write for the laity are requested to submit for approval any advertising matter expected to be connected with their writings so that there will be no

danger of their contravening the Principles of Ethics in the advertising

It was roted that Dr Moore's letter be answered and that a letter be sent also to Dr Spahr quoting this action taken by the Council.

Treasurer's Report was accepted

Report of Executive Officer

Dr Hannon reported that he had attended meetings of the Committees of the Society Also he attended the annual meeting of the Schenectady County Society on December 4, and the Chenango County Society annual meeting on December 9

Activities of Committees

Legislation -Dr Harry Aranow, chairman, reported that he had attended a hearing of the Joint Committee of the State Legislature on a proposed bill to insure people for expenses due to illness and unemployment not connected with their work.

Constitution and Bylaws -Dr James R Reuling, chairman, reported that the Medical Society of the County of Erie requested approval of a change in By laws regarding dues

Approval was roted Economics—The following report of the Director of the Bureau of Medical Care Insurance was submitted

Mr Farrell, director, attended a dinner at the Hotel Biltmore, November 19, 1947, at which a report on the progress of United Medical Service was The guest speaker was Mr Bernard M Baruch, who outlined a fifteen-point program to improve medical care

November 20, 1947 Mr Farrell was present at the Middle Atlantic States Conference in Philadelphia, sponsored by the Council on Medical Service of the A M A

November 24, 1947 The Director spoke before the Medical Society of the County of Clinton on the topic "Socialized Medicine and Medical Care Insur-ance" The interest shown by members of the Clinton County Medical Society in the Northeastern New York Medical Service Plan, Albany, was most gratifying It was suggested that a public relations campaign be launched from the county society level through the doctors, to increase enrollment as rapidly as possible

November 25, 1947 In the forenoon, Mr Farrell spoke before two senior sociology classes at Champlain College, Plattsburg That evening he de-bated with Dr Francis Wilson, Ph D, head of the Biology Department of the Associated Colleges of Upper New York, before the Faculty Club of Cham-plan College The subject was "Resolved, That Socialized Medicine Should Be Instituted in the

United States" Your Director, in conjunction December 1, 1947 with Mr Harry G Waltner, Jr, of the Standard Oil Company of New Jersey, spoke before the Mid-Hudson Industrial Association at Poughkeepsie Mr Waltner discussed "Compulsory Sickness Com-pensation" He gave a clear and thorough explanation of the programs which are now in operation in the states of Rhode Island and California, and outlined the fundamental differences in the programs He also described the so-called New Jersey program on which hearings were held in 1946

Fundamentally the difference in the New Jersey program, as compared to California and Rhode Island, is that the state only legislates the minimum standard benefits which will be underwritten by independent commercial insurance companies on a free enterprise and competitive basis The Medical Society of the State of New Jersey was in accord with the proposed program.

Mr Farrell discussed the compulsory health insurance angle, and questions from the floor were answered by both speakers on the two phases dis-

December 2, 1947 By invitation, Mr Farrell spoke before the Port Jervis Community Club, an affiliate of the Federation of Women's Clubs, on the subject of "Health Insurance" It was interesting to the speaker to note how little the group knew about compulsory health insurance and its implications

Finance -- Dr Albert F R. Andresen, chairman, reported that the budget submitted at the November meeting was to be voted upon.

It was roted that the budget as submitted at the November meeting be referred to the Board of Trustees with recommendation for its approval.

Defense and Insurance.—Dr Thomas M D'Angelo, chairman of the board and Mr Wanvig, insurance representative, and Mr Hackeling, auditor, were present Mr Wanvig pre-sented detailed facts and figures on charts Mr Hackeling spoke on the audit There was much discussion, but action was postponed until the Council has had time to study the facts

Office Administration and Policies -The Committee submitted a lengthy report on proposed changes and changes already in operation in office

procedure

Planning Committee for Medical Policies.—Dr Stanley Kenney, chairman, reported that the Committee held an important meeting on December 10 at which all members were present Group practice, possible reorganization of the District Branches, and the State of New York Program for the Care of the Chronically Ill were discussed A report will be presented at a subsequent meeting

Public Health and Education --Dr O W H.

Mitchell, chairman, reported as follows

Activities of the Chairman—On December 10
1947, in New York City, a meeting of the Council
Committee on Public Health and Education with representatives of the State Departments of Health and Labor and some of the officers of the Medical Society of the State of New York was held Areport on the activities of the Committee in the field of postgraduate education since the last annual meetmg was made and plans for the rest of the year, mcluding the Teaching Day on Tuesday of the next annual meeting, were discussed

Study Committee on Gernatrics —A meeting of the Study Committee on Gernatrics was held in New York City on Wednesday, November 19, 1947 Mimeographed copies of Dr. Monteith's report to be given at the hearing of the New York State Joint Legislative Committee on Problems of the Aging to be held on Thursday, December 11, 1947, in New York City, called by Senator Thomas C Desmond, will be distributed at a later date
Subcommittee on Nutrition—Norman S Moore,

M D , chairman "A meeting of the Subcommittee on Nutrition

was held in Albany on Friday, November 28 1947 Present for the State Society were Drs Anderton, Hannon, Beck, Jolliffe, Mitchell, and Moore, for the State Department of Health were Drs Hilleboe, Larimore, and Schlesinger

"The Commissioner of Health, Dr Hilleboe, outlined the objectives of the Food Commission in two

parts

The immediate 10b of saving grain which the Food Commission is handling but would like the cooperation and support of the Medical Society in such matters in which physicians can lend support during the emergency

'2 A long range program of the Food Commission which should involve long range planning in the State Department of Health with the

medical profession.

Considerable discussion about ways and means by which the medical group would be of assistance in the long range program crystallized into the follow ing possible ways that the Medical Society might be of assistance

Support the creation of a Nutrition Divi

sion in the State Health Department.

"2. Support the plea to the curricula committees of the various medical schools of the state to introduce more subject matter concerning nutrition in medical education.

Attempt to inform the physicians of the State regarding, nutrition and attempt to at imulate their interest particularly at the level of the general practitioner. This might be done

(a) Educational articles in the New York STATE JOURNAL OF MEDICINE using as a guide the Handbook of the Food and Autrition Board.

"(b) At annual meetings of Medical Societies work in special reports on the anthropological aspects of nutrition in various cultures and particularly our own culture as a means of stimulating interest.

(c) In the Committee on Public Health and Education, stimulate more programs on the subject of nutrition, perhaps changing the

formula to stimulate more interest.

'(d) Disseminate information regarding the importance of nutrition in all ago groups to the specialists in obstotrics, pediatrics, and geriatrics particularly and bring to the general practitioners of the state the value of a thera pcutic weapon in nutrition in all disease condi-

tions.
"4. Work out with the State Health Depart ment stipends for doctors who take advanced work in nutrition similar to the way in which plans have been worked out for special training in

cancer study

Support the State Health Department s request and the Food Commission's request, for appropriations for research to be carried out in the State at places where qualified nutrition clinics and educational facilities are adequate for special studios

It was roled that the report be approved.

The following is a report submitted by Dr William b. Ayling as a representative of the Medical Society of the State of New York to the conference on the Cooperation of the Physician in the School Health and Physical Education held at Hotel Moraine Highland Park, Illinois on October 16 to 18, 1947

This Conference was attended by prominent physicians health educators, and physical educators from all over the United States and even from Puerto Rico There was free discussion of the topics listed in the program and the general summary was made on Saturday morning Copies of this sum-mary will be available in the near future and as soon

as received one will be sent to you

Postgraduate Instruction —Postgraduate instruction is being presented in the following counties

Chonango, Clinton, Jefferson, Nassau Onondaga Ontario, Otsego St. Lawrenco Ulster and Wayne Requests for instruction to be given in the near

future have been received from Richmond, Schenectady and Sullivan County Medical Societies

Instruction has been completed in the following Broome, Cortland Dutchess Madison. Monroe Orange Oswego Steuben, and Tompkins Subcommittee on Rheumatic Fever -Dr Mitch

clistated that a proposal to give organized attention to rheumatic fever in his committee has been made The Tederal Government through the Children s Bureau has a program The State Health Depart ment also has one. Various foundations are being instituted to finance the study of rheumatic fever The latest one has and rheumatic heart disease. just been announced by the Masonic Lodge are said to be 750,000 Masons in the State of New lork who will probably contribute They have an Advisory Council to help them with their program It is recommended that we have a Subcommittee on Rheumatic Fever to help advise on rheumatic fover programs

It was roted that this recommendation be adopted

It was roted that Dr. Herman E. Hilleboo New 1 ork State Commissioner of Health be named as an advisor to the Council Committee on Public Health and Education.

Publication.-Dr George W Losmak, chairman, reported that the Publication Committee held its regular meeting on December 11 1947 at which time many details were discussed.

Liaison with the Veterans Administration.-Dr Herbert H. Bauckus chairman, reported regarding proposed changes in the fee schedule, as discussed at the meeting of the committee on November 13 1947 These changes will be discussed later with Dr Ethan Flagg Butler Branch Medical Director of the Veterans Administration. To further acquaint the Council I quote from my letter of December 2 to Dr Butler

"I have your note on the duties of the coordi nators Apparently this notice had been re-ceived by the coordinators sometimes before without our knowledge or approval, so I do not know that this makes any difference. I do, in general, approve of the duties as outlined in fact, to have them do anything that would enhance vetorans

I should like to comment upon the supervision of the medical care that the Veterans Medical Service Plan of New York, Inc. is supposed to have over the professional activities. Following the agreement of the first contract in September 1946, opinion spread among the veterans and the public in general that here was a type of service that the medical profession approved of as first class. Our coordinators were specifically directed to observe carefully the professional activities in

the program
I now want to point out that our coordinators have nothing to say about the professional care rendered in Isolities other than by the private practicing physician The recent great diversion from the home town personal care in New York State emphasizes this deficiency Thus the part program vitates much of the responsibility of the Medical Society for upholding high standards of medical practice

Steps should be taken to inform the veterans and the public of this fact We can no longer instances they are the only specialists available in

rural areas

"Under date of August 1, 1947, an opinion of the Attorney General was requested by Miss Donlon as to whether it was within the discretion of the Chairman of the Workmen's Compensation Board to deny authorization to a physician to render medical care under the Workmen's Compensation Law upon the ground that his other full-time employment by the State of New York would make him unavailable at all times to testify at referee and board hearings In this request the Attorney General was informed that the physicians had been recommended as duly qualified by the Medical Society

"Under date of August 19, 1947, Nathaniel L Goldstein, the Attorney General, submitted his reply, a copy of which was received in our office on

November 19, reading as follows

"Your letter of August 1 asks my opinion as to whether it is within the discretion of the Chairman of the Workmen's Compensation Board to decline authorization to a physician to render medical care under the Workmen's Compensation Law, upon the ground that his other full-time employment by the State of New York would make him unavailable at all times to testify at referee and board hearings form me that the physician has been recommended to you as duly qualified by the medical society of the county in which his office is lo-

"Section 13-b of the Workmen's Compensation Law provides that upon the recommendation by a medical practice committee or medical society or board, as the case may be, the Chairman of the Workmen's Compensation Board 'may' authorize physicians to render medical care under the Workmen's Compensation Law (subd 1), and that the recommendations 'shall be advisory to the chairman only and not be binding or conclusive upon him' (subd 2)

"The chairman thus has discretion to determine whether or not a physician recommended to him has the qualifications to merit authoriza-

"I cannot find that the mere fact that a physician is a full-time employee of the state is, without more, adequate reason for denying his application for authorization, since the bases of the application, and accordingly of the authorization, are 'training and qualifications' ization, are 'training and qualifications' (Workmen's Compensation Law Sec 13-b (2)

"Without doubt, the appearance of a physician at workmen's compensation hearings is an integral part of his rendering of medical service to employees. The fact that a physician is a full-time employee of the state does not, however, definitely presuppose that he would be unable to fulfill this obligation to patients whom he has treated under the Workmen's Compensa-

"A question might exist as to whether the conditions of a physician's employment in state service would permit him to accept private practice at all And there are certain positions held by physicians in state service which would be wholly inconsistent with their engaging in private workmen's compensation practice

"Where the physician at the time of making application is engaged in such inconsistent state employment as to affect his qualifications to render full medical service in workmen's compensation cases, including the obligation to

appear when necessary at workmen's compensation hearings, it would appear to me to be within the discretion of the chairman to decline to grant him authorization during the continuance of such employment Of course, each case would require determination upon its own particular facts '

Continuing

"The opinion of the Attorney General sustains the position taken by the State Society, and it would appear that we are on sound legal ground

"Section 19-b of the law prohibits physicians in the employ of the Workmen's Compensation Board, as examiners or director or as a member of the Industrial Council, from engaging in any form of insurance practice No such restrictions, it would seem, are placed upon the physicians in the employ of the state mental hospitals, as evidenced by the Civil Practice Act of this state The Commissioner of Mental Hygiene, in a communication to the Director of our Workmen's Compensation Bureau, is in agreement with this

"In the final paragraph of this opinion considerable discretion is also given to the chairman of the board in the granting or withholding of such

authorizations

"Your chairman took this matter up with Miss Donlon at his most recent conference with her The resolving of the difficulty would seem to be dependent on the willingness of the head of a state department-in this instance the Commissioner of Mental Hygiene—to authorize unequivocally, and without special permission from time to time, absences by his staff physicians to render medical care to Workmen's Compensation chents and to testify as required at Workmen's Compensation

hearings "The logical course to pursue to end this long controversy would be for the Council of the Medical Society to request that Dr MacCurdy, the Commissioner of Mental Hygiene, put in writing, based on his own beliefs and on this opinion of the Attorney General, his authorization permitting staff physicians in his department to render medical care to Workmen's Compensation clients and to testify as required at Workmen's Compensation hearings, and file this with the chairman of the Workmen's Compensation Board done, we are of the opinion that the authorizations now recommended by the Medical Society will be granted Failing in this, it would seem necessary for a physician who has been refused authorization

to have recourse to legal action"

Group Medical Practice—"The Rip Van Winkle Clinic of Hudson, New York, is a group of physicians practicing medicine under the name of the Rip Van Winkle Associates as a partnership, prac-ticing group medicine They are registered in the county clerk's office as doing business under an assumed name other than their own Compensation bills for services rendered by members of the group are rendered on billheads of the Rip Van Winkle Associates, the name of the particular doctor rendering the service being mentioned on the Where insurance carriers make out checks to the doctor, the latter endorses the check over to the Associates There is no question about the right of this group to practice medicine and divide fees under the provisions of the Amended Law of 1947 (Griffith-Milmoe Senate Int 740 of 1947) However, your attention is drawn to the fact that this law which amended the Education Law states no such sharing, division, or apportionment shall be permitted with respect to fees received for

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rendering medical care and treatment under the Workmen a Compensation Law A similar circumstance arose in New York City where the socalled Metropolitan Medical Group, formed und the HIP, inquired whether it was logal for the group to place compensation fees earned by d tors in the common funds of the group and si In accordance with the provisions of 1 the Workmen s Compensation Law and the cation Law, section one, paragraph f, subdiv of Section 1264 such sharing or apportions illegal in compensation cases

"This matter is brought to the attents Council before any further attempt is it bring this matter to the attention of the Wor men's Compensation Board and of the Rip Van

Whikle Associates

Your Director appeared before the Nassau County Medical Society on Tuesday, Nov 25, 1947 and conducted a symposium on Workmen s Compensation problems. On Dec 5 he partici pated in an arbitration session at White Plains.

On Dec. 3 he read a paper on physical medicine in relation to Workmen's Compensation practice before the Association of Physicists at the Polyclinic Hospital New York City On Dec. 6 he appeared as a member of a panel before the American Association of Anesthesiologists to discuss the relationship between anesthosiology

and the hospital

Legislation.— The chairman of the Council Committee and the director of the Bureau met with the chairman of the Legislative Committee several weeks ago in connection with legislation which we hope to have introduced at the 1948 session of the Legislature Your chairman has further discussed with the chairman of the Work men s Compensation Board our legislative program in so far as it relates to Workmen s Compen sation, and a conference is to be held on December 17 with the advisory council to Miss Donlon at which time the legislative proposals of the Depart ment of Labor will be presented

At this time the Council Committee on Work men a Compensation would recommend attend

to the following

"Senate Bill Int 1708 (Mr Condon) To amend the Workmen's Compensation Law in relation to the review, revision, or revocation of physiclans' authorization. This bill became law and

took effect July 7, 1947

Senate Bill Int. 2078 (Mr Halpern) To amend the Workmen's Compensation Lew in relation to the place of arbitration of medical bills We approve and recommend the reintroduction of this bill. It would change the law to make the place of arbitration of medical bills in the county in which the services were rendered rather than the county where the claimant resides.

It was roted that this be approved. Senate Bill Int. 2478 (Mr Fino) To amend the Workmen's Compensation Law in relation to the authorization of physicians, medical bureaus and laboratories and payment of medical fees This bill would abolish the Medical Practice Com-

"We have a mandate from the House of Dele-

gains regarding this measure.

Sonate Bill Int 618 (Mr Condon) To amoud the Workmen's Compensation Law in relation to the designation and compensation of medical specialists and examinations and reports by them. This bill is brought before the Council for discussion and clarification. Both the chairman of the ning, at a meeting of Fort Orange crean Association of Social Workers, tal on December 15 tal on December 15 Dr Donald York University Medical School Lhovaca, New York Polyclinic postgraduate course in physi postgraduate course in physical places of the course in physical places of the course of the core of

proper the lay that the Illin from \$10 to \$20 for

'Scnate Bill Int 722 (Dr. the Workmen s Compensation . the maintenance of medical bureau This bill was passed, and vetoe

and

"Our recommendation is to use our influence see that this bill is not reintroduced It origin ated in Chautaugua County gerous bill and every effort should be put forward to prevent its reintroduction

It was roted that the Society use its influence to see that the bill is not reintroduced

Assembly Bill Int. 2712. Introduced by Committee on Rules An act to amend the Workmen's Compensation Law in relation to claims for services in connection with x ray ex amination diagnosis or treatment of claimants by licensed laboratory or bureau of voluntary hospital.

"This is one of the mandated bills from the House of Delegates which requested our Council to test the validity of this act. It would appear that we stand little chance of doing anything about this. I am informed that any attempt to amend it will be opposed by the hospitals and the Governor We would recommend referring this to counsel for advice and disposition

The mandate of the House was not to introduce a bill but to test its legality In the opinion of the Counsel no case so far has presented itself which

would make a proper test case.

Assembly Bill Int. 1283 (Mr Clancy) To amend the Workmen's Compensation Law in relation to x ray diagnosis x-ray treatment and radium treatment. This is an excellent bill. It should be reintroduced and pushed strongly

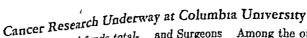
It was voted to sponsor this bill.

The Committee was given power to act with discretion after further conference with Miss Donlon and Mr Martin on the following. Medical Inspection under 13-1 to be in accordance with Section 13-a (4) that when an inspection is made, unless the doctor waives his right be has a right to be present and the patient has a right to designate him to be present and the enforcing of Section 13-g provides that if an insurance carrier or employer does not object to a doctor's bill within thirty days the bill is presumed to be fair and reasonable

Dr Kaliski stated that the Workmen's Compen sation Law was amended in 1947 to include in the

coverage the executives of corporations.

After discussion it was roted that Dr. Kaliski



OLUMBIA University has received funds total-COLUMBIA University has recently according to the American Cancer Society, ing \$28,376 from the American Cancer The funds Inc, for research and study on cancer The funds were payment on part of the numerous projects

underway on cancer research at the University

One of the largest gifts \$-\$7,368 was for the continued study of the application of the isotope technic to the problems of clinical medicine in man. The work is being carried on by the department of biochemistry, in the University's College of Physicians

and Surgeons Among the other projects provided for in the funds were research on cells in vitro, and research on nucleic acid of normal and cancer tissues, both by the department of surgery, and a study of animal tissues by the department of medicine

In addition, Columbia also announced receipt of a payment of \$2,250 from the New York City Cancer Committee of the American Cancer Society for clinical research on gynecologic cancer to be carried on by the department of obstetrics and gynecology

MEETINGS

PAST

Saranac Lake Medical Society

A discussion of streptomy cin featured the meeting A discussion Lake Medical Society held January 7 of the Saranae Lake Medical Society held January 7 of the Saranac Laboratory Speakers included Dr at the Saranac Laboratory Speakers included Dr Alcholas D'Esopo, United States Voterans Hospital, Sunnount, Dr Gordon Meade, Trudeau Sanator-um, and Dr James Monroe, Ray Brook Sanatorium.

Participating in the discussion were Dr E N Participating in Sanatorium, and Drs J N Hayes and Henry Leetch, of Saranac Lake

The Society of Medical Jurisprudence

Medical jurisprudence from the standpoints of the physician and the lawyer were topics of two speakers at the 630th meeting of the Society of Medical Junaprudence, held at the New York Academy of Medicane, New York City, on January 12

Dr Theodore J Curphey, president of the American Society of Chincal Pathologists and chief medi-

cal examiner of Nassau County, spoke on "Medical Jurisprudence from the Standpoint of the Physician, with Special Reference to the Role of the Pathologist," and Edward Holloway, president of the Society of Medical Jurisprudence, discussed "Medical Jurisprudence, discussed "Med cal Jurisprudence from the Standpoint of the Lawyer"

Rome and Murphy Memorial Hospital

A program of postgraduate instruction arranged by the Medical Society of the State of New York in cooperation with the State Department of Health, was presented at a staff meeting of the Rome and Murphy Memorial Hospital on January 20 in Rome

Guest speaker was Dr Richard H Lyons, professor of medicine, Syracuse University College of Medicine, whose topic was "Some Recent Advances in Therapy '

FUTURE

New York City Department of Health

A 1948 winter-spring seminar for physicians on the diagnosis, treatment, and management of veneral diseases is being held on Saturday mornings at the New York City Department of Health building, 125 Worth Street, Manhattan, starting at 10 30 No registration or fee is required

Meetings scheduled during February, with topics and speakers, are

February 7—"Interpretation of Serological Tests for Syphilis," Dr R C Arnold, senior surgeon, Venereal Disease Research Laboratory, US Public Health Service

February 14-"Latent Syphilis," Dr Bernard I Kaplan, physician, Sing Sing Prison

February 21-"Cardiovascular Syphilis," Dr

Samuel S Paley, cardiologist, Bronx and Harlem hospitals

February 28—"Syphilis in Pregnancy," Dr Norman Ingraham, associate director, Institute for the Study of Venereal Disease, University of Pennsylvania

New York Tuberculosis and Health Association

The annual conference of the New York Tuberculosis and Health Association will be held March 9, 1948, at the Hotel Pennsylvania, New York City

Authorities on tuberculosis, social hygiene, and health education will present papers at morning and afternoon sessions, and a guest speaker will be at the

luncheon meeting The Tuberculosis Sanatorium Conference of Metropolitan New York will meet simultaneously, to

elect officers for the coming year

PERSONALITIES

Retured

Dr Joseph Day Olin, Watertown, after 43 years of practice, retired January 1 at the age of seventythree A graduate of Albany Medical College in 1904, Dr Olm was associated with Dr L H Neuman in Albany, before establishing general practice in Watertown in 1907, after 15 years, limited his

practice to urology, was chief urologist of medical staffs of House of the Good Samaritan and Mercy Hospital, member Jefferson County Medical Society

Honored

Dr William Lathrop Love, East Hampton, who was recently awarded a certificate for "Distinguished

and Exceptional Public Service' by the New York City Department of Hospitals and the honor of "Consultant for Life Dr Marvin Proctor, "Consultant for Life Dr Marvin Proctor, assisting visiting ophthalmologist 1 onkers General Hospital who received a diploma making him a diplomate of the American College of Ophthal mology, was given a testimonual dinner on his recoipt of the diploma and for his 'outstanding work in the community' by Westchester Academy of Medicine in Rye recently

Appointed

Dr L Edward Cotter Red Hook, as assistant county medical examiner in Dutchess County, succeeding Dr John F Rogers, who retired December 1 1947 Dr Franklyn B Amos, Delmar as director of the new Office of Professional Recruitment and Training, in the State Department of Health.

Speakers

Dr David Abrahamsen, research associate Department of Psychiatry, Columbia University, a series of four lectures on What Makes a Criminal on January 9, 16 23 and 30 at the New School New York City Dr John J Bourke, oxecutive director of the Joint Hospital Survey and Planning Commission of New York State on Highlights in

Hospital Planning,' at a meeting of Fort Orango Chapter American Association of Social Workers, A. Covalt, New York University Medical School and Dr. Richard Kovacs, New York Polyclinic and Dr Auchard Kovacs, New 10rk relyening Medical School at the poetgraduate course in physical medicane and rehabilitation to be sponsored by the University of Texas, Medical Branch, from March 1 to 5 1948, in Galveston Texas Dr Anoch H Lowert Jamaica, chairman of the orthopedic section of the Queens County Medical Scoety who discussed special problems in providing facilities for Queens and aspects of cerebral palsy treatment at a meeting of the Queens Chapter of the Corebral Palsy Society of New York City, on November 24.

New Offices

Dr Allen G Gifford, who served for more than five years in the Army Medical Corps, in Pacific theater with 31st Division resumed general practice in Troy Dr Samuel Livingstone general practice in Madrid Dr Gerald C Matura, who served in U.S Army and was stationed with 164th General

Hospital in France, general practice in Schenoctady Dr A. L. Soresi, New York City, practice limited to treatment of pain and postoperative adhesions

COUNTY NEWS

Allegany County

The Allegany County Medical Society has unanimonely endorsed the plan for the proposed Allegany assay chorsed the plan for the proposed Allegan, county Health Department now under consideration. The plan as outlined, would improve the health of the citizens through establishing a modern beath department to control diseas, improve sanitation, and assure continued hospital facilities.

At the present time each village and town in the county has its own health district administered by part-time health officers, and the proposed plan would do away with duplication and overlapping serrices, and have a staff of trained, full-time

Broome County

Dr J A. Curran, president of the Long Island College of Medicine spoke on "An Interesting Spect of Medical Economics" at the annual meeting of the Broome County Medical Society held Decem-ber 94 in Binchanta. ber 9 in Binghamton.

Chautauqua County

With the cooperation of the Chautauqua County Medical Society committee for cancer research of which Dr Van S Laughlin, Westfield is chairman, the Chantauqua County branch of the American Camer Society is now being organized

Object of the county branch will be to coordinate within the boundaries of the county the activities of the New York State division of the society mittee composed of physicians and laymon has been camed to select officers and directors

Dutchess County

Dr Scott Lord Smith Poughkeepele commented upon the work of the county physicians in the city and county public assistance departments at the meeting of the Dutchess County Medical Society in December emphasizing the need for younger mem-

bers of the Society to cooperate

Members voted that a dinner be held in honor of
Dr. Robert W. Andrews Dr. F. Howell Greene, and other members of the Society who have practiced for fifty years or more
Officers nominated for 1048 include Dr Louis W

Stoller president, Dr Clifford A. Crispell vice-president Dr John F Rogers, secretary treasurer, and Drs. Donald Malven, Alexis Leonidoff and Scott Lord Smith delegates.

At the January meeting of the County Society held January 14 at the Hudson River State Hos-pital, Poughkeepne Dr Edward McDonald, as-sociate professor of gynecology at Albany Modical College spoke on 'Hystorectomy

The Physician Veterans of Dutchess County met on December 15 and elected the following officers Dr Neil C Stone president, Dr Archle L Neigh bors, first vice-president, Dr Philip V Buckley second vice-president and Dr Harold C Resenthal secretary freasurer

Members of the executive committee are Drs John Turga, E. Alan Larkin Arthur Robbins, and Frederick Zipser

Erie County

Dr E. Dean Babbage was elected president of the Eric County Medical Society at the annual meeting December 18 in Buffalo and assumed office at the

first 1048 meeting on January 27
Serving with him as officers, are Dr Roy L.
Scott first vice-president Dr Stephen A. Graczy,
second vice-president Dr Helon G Walker, secre-

tary, Dr Everett A Woodworth, treasurer, and Drs Arthur F Glaeser, Donald R McKay, Joseph O'Gorman, and Harry C Guess, delegates

At the annual meeting in December, it was voted

to increase the annual dues from \$20 to \$25

Long the dream of Dr William H Handel, Erie County medical director, the Erie County Department of Health began its official existence on January 1, 1948 Named as county health commissioner 18 Dr Berwyn F Mattison, Yonkers

Greene County

Members of the Greene County Medical Society have endorsed the Doctors' Plan of the United Medical Service, which already has 13,000 doctors in the New York area participating, and 700,000 subscribers

Herkimer County

Dr Robert W Dennis, Herkimer, was elected president of the Herkimer County Medical Society at the annual meeting held December 9 in Herkimer Also elected were Dr Nicholas Lill, Dolgeville, first vice-president, Dr Ernest Enzien, Frankfort, second vice-president, Dr W Jennings MacDonald, Maharit, thur may manage the artistic product of the product of Mohawk, third vice-president, and Dr Roy C Knowles, Little Falls, secretary-treasurer

Speaker at the meeting was Mr Thomas E Walsh, of the public relations bureau of the State

Society

Jefferson County

Dr Richard H Lyons, professor of medicine, Syracuse University College of Medicine, was guest speaker at the meeting of the Jefferson County Medical Society on January 8 in Watertown His topic was "Some Recent Advances in Therapy"

The program was northern Therapy"

The program was postgraduate instruction arranged by the Council Committee on Public Health

and Education of the State Society

Kings County

Former presidents of the Pediatric Section of the Kings County Medical Society were honored by the presentation of certificates of merit at the meeting

of the Section on January 26 in Brooklyn

Receiving certificates were Drs Charles F Fisher, Harry Apfel, Harry R. Litchfield, Ben Stoloff, Sydney Nussbaum, Irwin Schiff, Harry S Bikoff, Abraham M Litvak, and Henry Rascoff Dr Sidney Kramer, because of his duties as director of laboratories for the state of Michigan at Lansing, was unable to attend and receive his certificate

The presentations were made by Dr A. W Martin Marino, president of the Kings County Medical

Society

At this meeting, guest speaker was Dr H. W Dargeon, who discussed "Neoplastic Diseases in Infancy and Childhood"

Dr Lawson Wilkins will speak on "Endocrine Disturbances" at the next meeting of the Pediatric Section, to be held February 23 at the Kings County Medical Society Building, Brooklyn, beginning at 9 рм

Madison County

Dr Richard B Cuthbert, Canastota, was re-elected president of the Madison County Medical Society at its annual meeting November 27 in Oneida

Dr Eugene W Carpenter, Jr, was elected vicepresident, Dr Francis Pfaff, secretary, Dr J Frederick Rommell, Jr., treasurer, and Dr Felix Ottaviano, delegate

IN Y State J M

Monroe County

General practitioners may obtain greater representation on the staffs of hospitals, as the result of an effort begun by the Monroe County Medical Society at its meeting December 9, when members adopted a motion to hold a special meeting during the next three months for a detailed investigation of the matter

Dr Ellis B Soble was elected president of the Society, at the elections conducted at this meeting Serving with him are Dr John J Finigan, vicepresident, Dr Joseph A. Lane, secretary, Dr John L Norris, treasurer, and Drs Charles S Lakeman and Joseph P Henry, delegates to the State Society

Sponsored by the Monroe County Medical Society, a series of broadcasts are being presented on Saturday afternoons over Station WHAM, Rochester Theme for this year is "Your Doctor Speaks on Health and Disease"

Broadcasts during January included January 10—"Winter Hazards," Dr Hanson and Mr Edward Smith, Rochester Safeti

Council

January 17-"Infantile Paralysis," Dr Henry B Crawford and associates

January 24-"Diseases of the Skin." Drs. James

M Markin and J P Freedman

January 31—"Medical and Surgical Aspects of
the Peptic Ulcer," Drs Leonard Horn and Edward W Douglas

Nassau County

A holiday dinner dance was held December 5 at the Garden City Hotel by members of the Nassau County Medical Society and their guests Chairman of the entertainment committee was Dr Walter C Freese

Under the sponsorship of the Nassau County Tuberculosis Hospital, the Nassau County Department of Health, the Nassau County Tuberculosis and Public Health Association, and the public health committee of the Nassau County Medical Society, a village x-ray campaign was held in Valley Stream December 9, 10, and 11 Members of the Valley Stream Kiwanis Club, of the Girl Scouts, and of the Red Cross chapter assisted as receptionists and clerical workers

New York County

The Board of Estimate, at its meeting December 4, rejected the City Planning Commission's recent zoning amendment under which doctors and dentists not living in multiple dwellings in residential districts could have maintained offices on either of the The proposed first two floors of such structures zoning change, which had been approved by the New York County Medical Society and Dr Dean Clark, director of the Health Insurance Plan of New York, was ordered sent back to the City Planning Commission for further study

In urging approval of the change, the New York County Medical Society declared that it was necessary to avoid eviction of many doctors now maintaining offices on the second floors of multiple-dwel-

ling units.

When it rejected the amondment, the Board had before it communications from organizations of podiatnests, physiothorapists, optometrists, and architects, asking that their professions be covered by the goning change

Niagara County

Dr William W Pierce, Lockport, was elected president of the Niagara County Medical Society at its annual meeting in Lewiston on December 9

Others elected were Dr Joseph A. D Errico, Niagara Falla, president-elect, Dr Ernest M G Reger, Niagara Falls, vice-president Dr Charles M Dake, Jr., Niagara Falls, secretary and Dr Frederick A. Lowe, Niagara Falls, treasurer Dr William A. Peart, Sanborn, was elected dele-

rate to the State Society

Onondaga County

Dr J G Fred Hiss was elected president of the Onondaga County Medical Society at its meeting December 2 in Syracuso.

Other officers are Dr Lawrence E. Ehegartner vice-president, Dr Irving L. Ershler, secretary Dr A. Carl Hofmann, treasurer, and Drs. Lee E Gibson and Walter W Street delegates.

Syracuse needs a new hospital with 400 to 600 brd, according to a committee report of the Onon-dega County Medical Society prepared by Dr Gordon D Hoople and his investigating committee Even by special action of doctors and hospital

sationities, the critical shortage of hespital beds can not be solved, the report indicates. Statistics in cluded show that the total of general hospital beds at present is 1 198 and should be increased to 1 500

Queens County

Dr Alfred Angrist, Jamaica, was installed as president of the Queens County Medical Society at its January meeting, together with new officers chosen at the annual meeting in December

Ected to office were Dr Arthur A Fischl Artoria president-elect. Dr Ezra A Wolff, Forest Hills, secretary Dr William Benenson Flushing, adulant secretary Dr David Raskind, Forest Hills, treasurer, and Dr C Darwin Gackenheimer, Jameier and Statistics of the Company of the Comp Jamaica, assistant treasurer

Now members of the group are Dr Bertram W Miller, Flushing Dr Fred R. Brown, Forest Hills, Dr. Grace Frank and Eugene S Kaplan, both of Jamalea Dr Jeptha R. MacFarlane Bellaire Dr Moo M. Palmiano, St. Albans Dr W Gordon Podolsky Bayside Drs. Louis A. Price and Akram Staoul both & Lealine Height of Dr. Joseph H. Shaoul both of Jackson Heights, and Dr Joseph H.

Sirls, Kew Gardens.

Rensselaer County

Dr Clement J Handron was elected president of the Rensselser County Medical Society at the annual meeting held December 9 in Troy

Other officers elected include Dr Elizabeth Palmer vice-president, Dr H F Albrecht, Jr, secretar, Dr Henry C Engster treasurer, and Drs. R. P Doody and S H. Curtis, delegates.

Richmond County

Postgraduate instruction, arranged for the Rich mond County Medical Society by the Council Committee on Public Health and Education of the State Society will be held on Friday afternoons during February and March, at the United States Marine Hospital, Stapleton, Staten Island, beginning at 4.30 р.м

The topics and speakers for the four sessions in

February include

February 6- Headache Mechanisms. Charles Kunkle, instructor in medicine Cornell

University Medical College.

University Medical College.

February 13— 'Nervous Conditions Associated with Allergy, Dr Foster Kennedy professor of clinical medicine Cornell University Medical College February 20— Recent Advances in Psychiatry Dr S Bernard Wortis professor of psychiatry, New

York University College of Medicine February 27—"The Diagnoss and Treatment of Anemia," Dr Paul Recnikoff, professor of clinical medicine, Cornell University Medical College.

St. Lawrence County

Virus Pneumonia was discussed by Dr Paul C Clark, associate professor of clinical medicine and University College of Medicine, at the meeting of the St. Lawrence County Medical Society on Janu ary 15 at Potsdam.

Schenectedy County

Dr Nelson H. Rust Scotla, was elected president of the Schenectady County Medical Society at the annual meeting December 4 in Schenectady succeeding Dr. Harry R. Reynolds.
Dr. Stuart F. MacMillan was elected vice-presi-

dent. Re-elected were Dr Ralph E. Isabella, secre-

The elections were followed by a dinner meeting, at which music was furnished by Dr Glen Smith and his Medical Society orchestra.

Suffolk County

Dr George E. Anderson, clinical professor of medicine at the Long Island College of Medicine spoke on "Diabetes Medicine" at the meeting of the Suffolk County Medical Bociety held January 28 in Patchogue.

The program of postgraduate instruction was arranged by the State Society in cooperation with the State Department of Health.

Note the dates for the Annual Meeting of the Medical Somety of the State of New York-

May 17 to 21, 1948, Hotel Pennsylvania, New York City

HOSPITAL NEWS

Experimental Mental Hygiene Clinic to Open in Brooklyn

A N EXPERIMENTAL mental hygiene clinic to discover how mental hygiene services can be brought by the Health Department to the mass of New Yorkers, at a price they can afford, is to be opened this month at the Red Hook-Gowanus Health Centre in Brooklyn

The staff will be headed by a half-time psychiatrist, a full-time psychologist, a psychiatric nurse, psychiatric social worker, and a secretary For the present, only residents of the district will be Psychotic and neurotic cases will not be treated at the new clinic, which is designed for lesser mental disturbances that threaten to develop into serious disease if untreated, but will be referred to hospitals in the borough

Another duty of the clinic's staff will be to instruct the other Health Department clinical workers throughout the city in recognizing incipient mental Research into the mental health of the Red Hook-Govanus district, one of the poorest in New

York City, also will be attempted
Policy will be set by an advisory committee
named by Health Commissioner Harry S. Mustard under the advice of the New York Mental Hygiene Committee of the State Charities Aid Organization. This committee, composed of seventeen physicians and social workers, is headed by Dr Abraham Z Barhash, director of the division on community clinics of the National Committee for Mental Hygiene

Job Survey for Cardiac Cases at Bellevue

TWELVE-MONTH survey to determine the physical capacities of persons with heart disease and to advise those in unsuitable vocations has been opened at the Bellevue Hospital Cardiac Clinic by the New York University College of Medicine and the division of vocational rehabilitation of the New York State Department of Education, it was announced recently

Dr Clarence E de la Chapelle, associate dean of the college, said "this survey will probably provide the first analysis ever made of the physical, mental, and vocational capabilities of a large group of individuals with heart disease, as well as of their needs for occupational readjustments "

Expected to cover 1,000 new patients, the survey is an addition to the clinic's standard task of diagnosing and treating heart conditions and is an outgrowth of the work classification unit established in 1941 by the college and the United States Employment Service The service sent job applicants with heart disease to the unit, where their job capabilities were evaluated The precaution was taken to prevent heart disease sufferers from aggravating their conditions on unsuitable jobs

Awards by National Council for Cancer Study

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m awarded}^{
m HE}$ National Advisory Cancer Council has awarded \$593,130 to twenty-six medical schools in grants for improvement of cancer teaching Memorial Hospital in New York City received \$30,-000 for cancer pathology and medical training and an additional grant of more than \$100,000 for five research projects on cancer, the Columbia Univer-sity College of Physicians and Surgeons received \$23,976 for coordination of existing instructional

programs, the New York University College of Medicine received \$24,732 for improvement of cancer teaching, the New York Medical College re-ceived \$24,900 for the teaching of neoplastic diseases, the University of Rochester received \$25,000 for improvement of teaching and research in neoplastic diseases, and Syracuse University Medical College received \$24,900 for improved cancer teaching

NEWS NOTES

To ease the pressure upon Huntington Hospital's facilities, a new wing is to be added to the present It will provide a larger children's ward on the first floor, a five-bed women's medical ward on the second floor, and additional private and semi-private beds on the third floor. This will bring the total capacity of the hospital to 95 beds plus 22 basinettes

The first in the American Hospital Association's 1948 series of institutes on hospital personnel relations will be held at the Henry Grady Hotel, Atlanta, Georgia, on February 23, 24, and 25 Planned to give assistance and to stimulate conscious planning for improved employee relations, the institute is not designed to train personnel officers but to aid hospital administrators develop and maintain efficient work forces which will result in better patient care and more effective and economical operations

Dr B C J G Knight of the Wellcome Physio-logical Research Laboratories Beckenham Kent, England, spoke on 'Essential Motabolites and Anti-metabolites' at the William Henry Welch Lecture at Mount Sinai Hospital, New York City, on Janu-

The Atomic Energy Commission has approved expenditure of \$615 000 to provide a center at the University of Rochester for training doctors and technicians in meeting problems of atomic energy development The money will be used the com mission said, to build and equip a six-story medical and biological training and research center

Plans for a six-story building the first stage in a three-stage plan which will result eventually in a completely new hospital for Bronxville were an nounced recently by James A. Lyles, president of the Lawrence Hospital board of governors.

With the completion of the new building, the hospital's present 104-bed capacity will be increased to about 100 beds Mr Lyles said, and when the ulti-mate goal is realized there will be between 250 and 300 beds. All of the building operations will be on

the present site

The Yates County Memorial Committee appointed nearly two years ago has agreed that the proposed wing of the Soldiers and Sallors Memorial Rospital in Penn Yan shall be designated as a mem orial for those who died in military service during World War II

The board of directors has arranged that in the new 22-bed wing, departments, beds, rooms, and services may be sponsored by individuals as mem orials for their loved ones.

The new wing will allow also for expansion of the maternity department, provide a more adequate nursery will house the pathologic and clinical labora tory and permit the establishment of a children s department a service long needing larger quarters A complete new laundry will be added and what the directors call "the most heartening aspect' of all will be the establishment of a much needed emer gency operating room and admission room.

Establishment of a rehabilitation clinic especially designed for the treatment of patients disabled by cerebral-vascular accidents has been announced by Beth Israel Hospital New York City The clinic will also train individuals, mostly in the upper-ago brackets who suffer from hardening of the arteries and high blood pressure, to live useful lives within the limits of their disability Eventually according to Dr Maxwell S Frank, hospital director the clinic will broaden the program to include other types of dısability

The Council of Rochester Regional Hospitals has recommended to the board of directors of F F
Thompson Memorial Hospital that a new 50-bed
wing be constructed to provide badly needed space
and other new facilities for the Canandaigua institu tion When Thompson Hospital was completed in 1904 it could care for 34 patients. The addition of a wing for the maternity section increased the capacity of the hospital to 70 beds. In more recent years shifting of facilities and the use of the hospital porches has made the hospital a 96-bed institution

Lockport City Hospital has recently reopened a 22-bed section, closed for eighteen months because of the shortage of nurses. New members are still needed for the nursing staff however

Plans are underway for the enlargement of the Southside Hospital, Bay Shore with the addition of two new wings and a large central annex. Private rooms are to be increased from 19 to 87 semiprivate rooms from 20 to 52 and the four and five-bed rooms and nursery rooms also will be increased

The Brooklyn State Hospital Psychiatric Forum will hold meetings regularly on the first Thursday of Meetings will take each month throughout May place in the auditorium of Brooklyn State Hospital 081 Clarkson Avenue, at 8 30 p.m

Dr Franklin Hanger professor of medicine at Columbia University, College of Physicians and Sur geons and chief of medicine at Columbia Presby terian Medical Center New York City, was guest speaker at the January staff meeting at the Veterans Administration Hospital Castle Point His subject was disorders of the pancreas

At the December meeting of the staff of Vassar Brothers Hospital, Poughleepsie, Dr J R. Lock wood presented a review of the cardiac cases admitted to the adult medical ward from June 1, 1946 to June 1 1947 The discussion was by Dr Scott Lord Smith and Dr Reuben T Lapidus

PERSONALITIES

Honored.—The late Dr Arthur Wright Benson, pediatrician, whose guiding hand created and surfaced the Troy Day Home Clinic through three decades of service to the Troy community at ceremonists in Transfer and the Troy community. ies in December dedicating the clinic in his name

Elected.—As officers of the medical staff of Oswego Hospital Dr. K. W. Javvis president, Dr. Olin J. Mowry vice-president, and Dr. John F. Burden, secretary Dr. Charles B. C. The Burden, secretary (Jana Jan [Continued on page 323]

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NECROLOGY

Harry E Braner, M D, died on December 2 at the age of sixty-five at his home in Hamburg. A graduate of the University of Buffalo Medical School in 1905, Dr. Braner opened his office in Hamburg in 1909, and during World War I he was the only physician in the town. He was on the staffs of the Lady of Victory and the Millard Fillmore hospitals, Buffalo. Dr. Braner was a member of the Buffalo Academy of Medicine, the American Medical Association, and the New York State and Erie County medical societies.

Arthur Wells Elting, M D, of Albany, died on January 2 He was seventy-five years of age Dr Elting was graduated from Johns Hopkins University College of Medicine in 1898 He was a member of the New York State and Eric County medical societies, the American Medical Association, and the American Surgical Society, and a fellow of the

American College of Surgeons

William Murray Ennis, M D, of Brooklyn, died on December 26 He was fifty-nine years of age Dr Ennis was graduated from Fordham University College of Medicine in 1910 He was on the staffs of the Kings County and St Peter's hospitals, Brooklyn. He was a fellow of the American College of Surgeons and a member of the Brooklyn Surgical Society, the New York State and Kings County medical societies, and the American Medical Association

Benjamin P Farrell, M D, New York City, died on December 27 at the age of seventy-seven Retiring in 1940, Dr Farrell was chief surgeon of the New York Orthopaedic Dispensary and Hospital He was appointed to the faculty of the College of Physicians and Surgeons, Columbia University, in 1918, and at his retirement was professor of orthopedic surgery Dr Farrell also served as chief of the medical staff of the House of the Holy Comforter, the Bronx, and as consultant to the Englewood, New Jersey, Hospital. In 1904 Dr Farrell received his medical degree from the Long Island College Medical School and served his internship at the Newark, New Jersey, City Hospital

the Newark, New Jersey, City Hospital

Benjamin Franklin Gallant, M D, of Northport, died on November 21 Dr Gallant was graduated from the University of Maryland College of Medicine in 1913 and also did postgraduate work in Berlin and London. Since 1929 he had been engaged in private practice in Huntington and Northport He was a member of the staff of Mather Memorial Hospital, Port Jefferson He was also a member of the New York State and Suffolk County medical societies, and the American Medical Asso-

ciation

Charles Nicholas Harper, MD, of New York City, died on November 26 He was fifty-seven years of age Attending physician in otolaryngology at Roosevelt Hospital, Dr Harper was also consultant to the New York Infirmary He was graduated from the University of Virginia College of Medicine in 1915 He was a member of the New York County and State medical societies, and the American Medical Association

Anna M McFee, M D, formerly of New York City, died on December 21 in Montreal, Canada She was ninety-two years of age—She received her medical degree from the University of Toronto in 1897 and did postgraduate work at the Royal College of Physicians and Surgeons, Edinburgh, Scotland Dr McFee interned at City Hospital, New York City, and practiced there for twenty years

prior to her retirement in 1917

Willis Grafton Nealley, M D, Brooklyn and Montclair, New Jersey, died on January 7 at the age of sixty-five A graduate of Dartmouth Medical School in 1907, Dr. Nealley became director of the Brooklyn Hospital in 1912, and upon his retirement in 1946 he received the title of director emeritus as a tribute to his administration. He was also an organizer and first president of the Greater New York Hospital Association, which was formed in 1937. In 1934 he was a member of a special board created to advise the City Department of Hospitals on its plans for reorganization. Dr. Nealley was a member of the American Hospital Association, and the New York State and Kings County medical societies.

Edward Wright Peet, M D, of Pomona and New York City, died on January 3 He was eighty-five years of age He was graduated from the College of Physicians and Surgeons, Columbia University, in 1890, and practiced in New York City until he retired in 1945 He was a member of the New York Academy of Medicine, the New York State and County medical societies, and the American Medical

Association

Max Pinner, MD, formerly of the Bronx and Bedford Hills, died on January 7 at his home in Berkeley, California He was fifty-six years of age The author of Pulmonary Tuberculosis in the Adult, Dr Pinner was chief of the division of pulmonary diseases at Montefiore Hospital, New York City, from 1938 until his retirement two years ago He received his medical degree from the University of Tübingen, Germany, in 1920 Coming to America in 1921, he was associated with the Municipal Tuberculosis Sanatorium, Chicago, the Health Department of the City of Detroit, the Institute of Research at the Desert Sanatorium, Tucson, Arizona, and in 1935 was appointed principal diagnostic pathologist of the New York State Tuberculosis hospitals at Oneonta, Ithaca, and Mount Morris Healso was appointed clinical professor at Columbia University in 1938

Dr Pinner had been editor of the Review of Tuberculosis since 1939 He was awarded the Trudeau Medal of the National Tuberculosis Association in 1946 He was a fellow of the American College of Physicians and a member of the American Society of Pathologists and Bacteriologists, the American Thoracic Surgery Society, the New York Academy of Medicine, the National Tuberculosis Association, the American Medical Association, and the New York State and Bronx County medical societies

Nathan Ratnoff, M D, of New York City, died on December 23 at the age of seventy-two Founder and president of the American Jewish Physicians Committee, Dr Ratnoff devoted much of his time to work resulting in the establishment of a medical school of the Hebrew University in Palestine He was also founder of the Jewish Maternity Hospital, which merged in 1930 with Beth Israel Hospital He was medical director of Beth Israel from 1930 until 1945, becoming consultant in that year

Dr Ratnoff obtained his medical degree from the

[Continued on page 828]

WOMAN'S AUXILIARY

TO THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

Plans Announced for 12th Annual Auxiliary Convention

ARRANGEMENTS for the 12th Annual Convention of the Woman's Auxiliary to be held at the Hotel Pennsylvania, New York City, from May 17 to 21 1948, are now being planned under the direction of Mrs. Clifton L. Dance, Brooklyn, chairman of the State convention and Mrs. William Lavelle Long Island cochairman

With every organized county in the State represented by delegates the convention is expected to be

the largest in the Auxiliary's history

All doctors wives, whether or not they are members of a county Woman's Auxiliary are invited to attend this convention and to participate in the pro-

Since the Auxillary meeting coincides with the 142nd Annual Meeting of the Medical Society of the State of New York, also to be held at the Hotel Pennsylvania, a number of social and entertainment events are being planned for the wives who accompany their husbands

Midwinter Executive Board Meeting Held

WITH State President, Mrs. Harry F Pohlmann, Middletown, presiding, the midwinter meeting of the executive board of the Woman s Auxiliary to the Medical Society of the State of New lork was held January 6 and 7 in Rochester Nineteen of the 42 organised county groups were represented at the session

Dr Elton R. Dickson Binghamton, a member of the advisory council for the State Auxiliary brought greetings from the State Society and discussed medi-cal care plans and the need for active interest in State and federal legislation affecting the medical Profession.

"Women in England' was the topic of a talk by Mrs. Dexter Perkins, who has edited several edi tions of the Fannie Farmer Boston Cook Book

Reports from various officers revealed that all the Anxiliance are actively engaged in public relations work and are ready to continue their active interest in legislation affecting the medical profession

On the recommendation of Mrs. Bradford F Golly finance chairman a resolution was adopted Instructing counties to make checks payable to the Physicians' Home, thus eliminating the necessity of the the checks payable to the Physicians' Home, thus eliminating the draw sense. the State Auxiliary treasurer having to draw sepa rate checks for each county contribution to the Home. Checks can be mailed to the State Auxiliary chaliman of the Physicians' Home, Mrs George P Bergman, who will in turn send them to Dr Wallace B. Hamilton, State Society chairman for the Home. This action was decided following Mrs. Golly's recommendation and considerable discussion among the group

At Wednesday morning's meeting, the points presented for the Auxiliary by the State Medical Society chairmen for public relations and legislation were discussed as was the advasability of Auxiliary members attending public meetings of other organi-zations where medical topics are under discussion.

In order to distribute annual reports, a resolution was passed to the effect that the district councillors synopsize county president reports and that these reports be mimeographed with the State President s report, for distribution.

Announcement was made of the State Convention at the Hotel Pennsylvania, New York, from May 17 to 21, and of the national convention at the LaSalle Hotel Chicago from June 21 to 25 Delegates and officers were urged to make early reservations

With members of the Monroe County Auxiliary acting as hostesses the session was most successful. In charge were Mrs. Harry I. Norton, seventh dis-trict councillor and Mrs. Charles I. Miller Monroe

County Auxiliary president

Roving reporters from Station WVET interviewed members of the Auxiliary in the Hotel Seneca during room at breakfast, giving them an opportunity to explain the alms and objects of the Woman's Auxiliary The Monroe County Auxiliary press and publicity chairman, Mrs. Montgomery Leary arranged for a reporter and photographer to cover the Wedneeday meeting.

COUNTY NEWS

Dutchess County

The Woman's Auxiliary to the Dutchess County Medical Society held a Christmas party December 10 at the Golf Clubhouse Hudson River State Reprint Mrs. Frederick J. DeNatale was hostess. actuated by Mrs. Albert Lafleur and Mrs. Donald Schwartz. Christmas decorations were featured, and gifts were exchanged.

No meeting of the Auxiliary was held in January

Erie County

The first monthly meeting for 1948 of the Woman's Auxiliary to the Eric County Medical Society was held January 27 at the Hotel Statler Buffalo, with a luncheon and business meeting

A new constitution for the Auxiliary, presented by Mrs. Benjamin Smallen, chairman of the special committee on revision of the constitution was given its first official reading. 328

Additional feature of the January meeting was an address on "Interior Decorating"

Queens County

Officers of the Woman's Auxliary to the Queens County Medical Society were installed December 9 at a luncheon meeting in New York City, with Mrs William Godfrey, Flushing, serving as the inducting officer Mrs Thomas D'Angelo, Flushing, was chairman of the luncheon

Taking office were Mrs Daniel Swan, Flushing,

president, Mrs William Flanagan, Richmond Hill, vice-president, MrsJohn Finnegan, Flushing, treasurer, Mrs John Keating, Forest Hills, assistant treasurer, Mrs Benjamin Coleman, Kew Gardens, secretary, and Mrs Harry Secky, Astona. historian

Delegates to the State convention are Mrs Harold Foster, Corona, retiring president, Mrs Joseph Hallinan, Richmond Hill, and Mrs James Dobbins, Flushing

Mrs Samuel Klein, Jackson Heights, was chosen president-elect, to take office January 1, 1949

HOSPITAL NEWS

[Continued from page 325]

elected, chief of medical staff, Highland Hospital, As president of the staff of Lockport City Hospital, Dr George H Barone, as vice-president, Dr H Braden Fitz-Gerald, and secretary, Dr Wilfrid M Anna Dr Jacob Geiger, chair-Dr Wilfrid M Anna Dr Jacob Geiger, chairman, and Dr Isadore Givner, secretary, the Clinical Conference Society of Beth David Hospital, New As officers of the medical board of York City Beth David Hospital, Dr Samuel Malisoff, president, Dr Theodore M Sanders, vice-president, and Dr Samuel Games, secretary-treasurer

Dr Donald R McKay, president, Dr Walter F King, vice-president, Dr Ernest L Brodie, treas-urer, and Dr Elmer Friedland, secretary, all of the Edward J Meyer Memorial Hospital, Buffalo

Promoted -To associate attendants at Flushing Hospital, Queens, Dr Daniel R Kaufman, chief of urology in Army general hospitals in the United States and England during World War II, and Dr Hamden C Moody, formerly with the Naval Medical Corps As clinical professor in New York Polyclinic Medical School and Hospital, Dr. Paul W Dr Benjamin Segal as gynecologist and obstetrician at Lincoln Hospital, the Bronx

Appointed —To the medical staff of the Little Falls Hospital, Dr William A Jarrett, formerly of the department of radiation therapy for malignant diseases, Roswell Park Memorial Hospital, Buffalo

Dr John P Bruckner as director of surgery, the Lutheran Hospital, New York City To the Veterans Administration Hospital, New Castle, Pennsylvania, Dr Thomas March, formerly supervising psychiatrist, Hudson River State Hospital, Poughkeepsie

At Roslyn Park Hospital, as chief of ophthalmology, Dr Milo H Fritz, and as chief of dermatolog, Dr Fred F Schirck To the medical board, Dr Charles J Leslie, Manhasset, Dr Richard L Jones, Glen Cove, and Dr J Rembrandt Helfrick, Port Washington

Richard I Kilstein, acting attendant in gastroenterology at Beth David Hospital, New York City, as consultant gastroenterologist, Will Rogers Memorial Hospital, Saranac, succeeding the late Dr John L Kantor To the Veterans Administration Hospital, San Bernardino, California, Dr Joseph Heller, formerly senior psychiatrist, Hudson River State Hospital, Poughkeepsie

NECROLOGY

[Continued from page 326]

Medical College of the University of Baltimore in He was a member of the New York Academy of Medicine, the New York State and County medical societies, and the American Medical Association For fifteen years he was a trustee of the Federation of

Jewish Philanthropies of New York

Mae Catherine Schroeder, M D, of New York
City, died on December 9 She was seventy-five City, died on December 9 years of age and was graduated from Tufts Medical College in 1900 Dr Schroeder was a member of the New York City Department of Health for twenty-eight years, until her retirement in 1935, when she was assistant director of the Bureau of Laboratories

Anthony Domenico Semisa, M D, of New York City, died in January He was sixty-two years of Dr Semisa was graduated from the New York Homeopathic Medical College in 1913 He was a member of the staffs of the Stuyvesant Polyclinic

and Manhattan General hospitals He was also a member of the New York State and County medical societies and the American Medical Association

Ferdinand Francis Siegel, M D, of Brooklyn, died on December 5 He was fifty-six years of age. Dr Siegel was graduated from the Long Island Hospital College of Medicine in 1916 He was a member of the New York State and Kings County medical societies and the American Medical Association.

Patrick Joseph York, M.D., of Brooklyn, died on November 25 A graduate of the Long Island Hos-pital College of Medicine in 1897, Dr. York was for many years a police surgeon and had been attending physician at St Peter's Hospital, Brooklyn, for twenty-five years He had also served on the staffs of the Kings County and Long Island College hospitals He was a member of the Kings County Medical Society and the American Medical Associa-



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Bronx		G B Gilmore Brony	C W Frank Bronx
Broome		R. S McKeeby Binghamton	J W Kane Binghamton
Cattaraugus	J S Fleming Salamanca	TTT TO 4 .17 ~ O1	777 TO A 1 Olean
Cayuga		J D Hammond Auburn	L H Rothschild Auburn
Chautauqua	E O Black Fredoma	Edgar Dieber Dunkirk	O E Hanenoeck Dankark
Chemung			E S Ridall Elmira
Chenango,	J A. Hollis Norwich	J H Stewart Norwich	J H Stewart Norwich
Clinton	W W Johnson Plattsburg		K. M Clough Plattsburg
Columbia	L D Carpenter Germantown	L J Early Hudson	L J Early Hudson
Cortland	R. H. Kerr Cortland	E F Higgins Cortland	F F Sornberger Cortland
Delaware	C K Ives Roybury	S D Edgerton Delhi	S D Edgerton Delh
Dutchess	L W Stoller Red Hook	J F Rogers Poughkeepsie	
Erle		H G Walker Buffalo	E A. Woodworth Kenmore J E Glavin Port Henry
Essex	J M Walsh Treonderoga	J E Glavin Port Henry	
Franklın		D H Van Dyke Malone R K Lenz Gloversville	D H Van Dyke Malone W H Raymond Johnstown
Fulton		C C Koester Batavia	C C Koester Batavia
Genesee	W A Petry Catskill		M H. Atkinson Catskill
Greene Herkimer		R C Knowles Little Falls	R. C Knowles Little Falls
Tefferson			L E Henderson Watertown
Kings	A. W M Marino Brooklyn		H Mandelbaum Brooklyn
Lewis			E A Barnes Lowville
Livingston	F J Hamilton Hemlock		R. A. Hemphill Mt. Morris
Madison	R. B Cuthbert Canastota	F O Pfaff Oneida	J F Rommel Oneida
Monroe	E B Soble Rochester		J. J. Norris Rochester
Montgomery	R. H Juchli Amsterdam	D W Childs Amsterdam	M J Kızun Amsterdam
Nassau	E K Horton Rockville Centre	I Drabkin Rockville Centre	
New York	H B Davidson New York	B W Hamilton New York	C W Cutler New York
Niagara		C M Dake Niagara Falls	
Oneida			R. C Hall Utica
Onondaga		I L Ershler Syracuse	A. C Hofmann Syracuse
Ontario	L A. Stetson Canandargua	P M Standish Canandaigua	E C Waterbury Newburgh
Orange	T R. Proper Newburgh	E C Waterbury Newburgh J G Parke Albion	
Orleans	A. F Leone Medina J. L H Mason Pulaski	U Cimildoro Oswego	
Oswego Otsego	E J Keegan Oneonta	J M Constantine Oneonta	J M Constantine Oneonta
Putnam		F J A Lehr Carmel	G H. Steacy Mahopac
Oueens		E A Wolff Forest Hills	D M. Raskind LongIslandCity
Rensselaer	C J Handron Trov	H F Albrecht Trov	H C Engster 1709
Richmond	S C Pettit St George	Michael Swick Tompkinsville	H Dangerfield St George
Rockland		R. L Yeager Pomona	M R. Hopper Nyack
St. Lawrence	P T McGreevy Massena	C F Prairie Massena	L T McNulty Potsdam
Saratoga	F A Mastrianni	M J Magovern	J M Lebowich
	Mechanicville	Saratoga	Saratoga
Schenectady		R. E Isabella Schenectady	Harry Miller Schenectady
Schoharie	J H Wadsworth Cobleskill	D. R. Lyon Middleburg	D L Best Middleburg
Schuyler	F C Ward Odessa	C W Schmidt Montour Falls Bruno Riemer Romulus	Bruno Riemer Romulus
Seneca		R J Shafer Corning	Bruno Riemer Romulus R. J Shafer Corning
Steuben	· ·	E P Kolb Holtsville	G A Silliman Sayville
Suffolk	W S Stakes Patchogue R. S Breakey Montucello	D S Payne Liberty	D S Payne Liberty
Sullivan	H S Fish Waverly		P E Zoltowski Waverly
Tioga Tompkins	H W Ferris Ithaca	Richmond Douglass _ Ithaca	Richmond Douglass Ithaca
Ulster	E S Goodyear Kingston	F H Voss Phoenicia	H B Johnson Kingston
Warren	J A Glenn North Creek	A. C Davis Glens Falls	A C Davis Glens Falls
Washington	R. L. Skinner Greenwich	D M Vickers Cambridge	C A. Prescott Hudson Falls
Wayne	J H Arseneau Lyons	I M Derby Newark	I M Derby Newark
Westchester	W G Childress Valhalla	W A Kelly Mount Vernon	R R. Heffner New Rochelle P A. Burgeson Warsaw
Wyoming	O T Ghent Warsaw	P A Burgeson Warsaw	
Yates	R. H Davis Penn Yan	W G Roberts Penn Yan	W G Roberts Penn Yan
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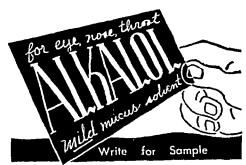
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REVIEWED

Handbook of Psychiatry By Winfred Overholser, M.D., and Winifred V. Richmond, Ph.D. Octavo of 252 pages Philadelphia, J. B. Lippincott, 1947 Cloth, \$4.00

Written chiefly for the "nontechnical reader" and covering briefly almost the whole range of personality disturbances, this book by two authorities from St Elizabeth's Hospital in Washington, D.C., can be warmly recommended

ANDREW BABET

Sir W Arbuthnot Lane, Bart., C.B., MS, F.R.CS His Life and Work By W E Tanner, FRCS Octave of 192 pages, illustrated. Baltimore, Williams & Wilkins Company, 1946 Cloth, \$450

This is an interesting and instructive biography of one of the great in medicine and surgery. It is somewhat unusual in that the author is free in his quotations from those who refused to follow Dr Lane in all pronouncements. To those of us who were active in the days of Lane's kink, intestinal stasis with colectomy, the book is nostalgic. Lane's contributions were more vital and lasting than these. He was among the first to emphasize the necessity of surgical asepsis.

JOSEPH RAPHAEL

Pharmacology, Therapeutics, and Prescription Writing For Students and Practitioners By Walter Arthur Bastedo, M D Fifth edition Octavo of 840 pages, illustrated Philadelphia, W B Saunders Co , 1947 Cloth, \$8 50

The fifth edition continues much the same as previous ones. Although the newer drugs of importance are included, such as the anti-histaminics, anticoagulants, folic acid, thiouracil, and the anti-biotics, hardly more than a paragraph or a page is devoted to each. This is not a learned book, the references are poor. There is little on the chemistry of drugs, but it contains many hints which will appeal to the practitioner. Pharmacology from the toxicologic viewpoint is well covered.

JOSEPH R DI PALMA

Diagnostic Examination of the Eye Step-by-Step Procedure By Conrad Berens, M.D., and Joshua Zuckerman, M.D. Octavo of 711 pages, illustrated Philadelphia, J. B. Lippincott, 1946 Cloth, \$15

This book is organized skillfully into three main divisions. Part one includes the method of taking a proper history, evaluation of the complaints of the patient, and a correct determination of visual acuity. The second part describes the test for fusion, the postcycloplegic examination, and the determination of depth perception. The third part includes a clear description of the use of the more common and uncommon instruments employed in ophthalmology, such as the exophthalmometer, the rotary cross cylinder, the tonometer, and the biophotometer. This book gives the ophthalmologist and the general practitioner an opportunity to observe a clear method of a thorough and complete diagnostic examination of the eyes of both adults and children.

NORRIS C ELVIN

[Continued on page 334]

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BOOKS

[Continued from page 332]

By J A. C Brown Psychiatry for Everyman M B Duodeeimo of 247 pages New York Philosophical Library, 1947 Cloth, \$3 00

This is a sound, reliable, and not too complicated résumé of some basic theories in psychiatry Ita well written and well balanced and should appeal to the lay public for whom it was written.

ANDREW BABET

Office Endocrinology By Robert B Greenblatt, D Third edition Octavo of 303 pages, illustrations MDSpringfield, Ill., Charles C Thomas, 1947 Cloth, \$4 75

This work, now in its third edition, is a popular book much appreciated by practicing gynecologists who derive sound advice for the treatment of many of the common gynecologic ailments of endocrate origin The treatment of other endocrine conditions is only touched upon and does not seem to form an essential part of this book Criticism of these shortcomings could be avoided if the title of the book were changed to fit its intended limitations

MAX A GOLDZIEHER

Are You Considering Psychoanalysis? Edited by Karen Horney, M D Octavo of 262 pages. New York, W W Norton & Company, 1946 Cloth, \$300 The intent of the authors is an excellent one.

With the increasing interest in psychologic problems, more people are considering being analyzed Many doubts assail them What is analysis? Whom shall they consult? What shall they expect of the analyst? The authors seek to answer these questions simply and sincerely However, one wonders if they have not lost sight of their intent when they are the same of the same appeals of enter into a discussion of the various schools of psychoanalysis and attempt to evaluate them This would seem to confuse the prospective patient rather than aid him The detailed discussion of what constitutes a neurosis also seems needless, \$ page or two would have served better The general practitioner will benefit from reading the book more readily than the prospective patient

JOSEPH L ABRAMSON

Internal Medicine in General Practice By Robert Pratt McCombs, M D Second edition. Octavo of 741 pages, illustrated Philadelphis, W B Saunders Co, 1947 Cloth, \$800

Dr McCombs is now senior attending physician at the Pratt Diagnostic Hospital The work is clearly written and has the same high excellence as the first edition Chapters on psychiatric disorders and common vascular diseases of the extremities have been added The book has been brought up to date m the realm of the newer therapeutics The medical student, general practitioner, and specialist in extra medical departments will find it very practical.

MEYER A RABINOWITZ

Office Immunology, Including Allergy for the Practitioner Edited by Marion B Sult berger and Rudolf L. Baer Octavo of 420 pages, illustrated Color 1047 Chicago, Year Book Publishers, 1947 illustrated Cloth, \$6 50

The authors attempt in this book to bring to gether in one volume most of the practical features of

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[Continued from page 334]

immunology and allergy as applied to everyday practice. They have included a great amount of useful information on diagnostic procedures, their execution and interpretation, as well as the names of pharmaceutical houses which produce the material in question. For quick ready reference this book is good, but there are many things not covered.

ANDREW BABEY

The Medical Clinics of North America Mayo Clinic Number July, 1947 Octavo Philadelphia, W B Saunders Co, 1947 Published Bi-Monthly (six numbers a year) Cloth, \$16 net, paper, \$12 net.

The Mayo Clime Number of the Medical Climics of North America contains a symposium on blood transfusion and the Rh factor. Outstanding are papers on radiophosphorus, the treatment of myasthenia gravis, histamine antagonists, atomic energy in medical practice, and a consideration of "certain diseases of international importance"

Among the more conventional "clinics" are lengthy ones on uremia, spondylitis, convulsive disorders in children, exfoliative dermatitis, and the diagnosis of duodenal ulcer This is one of the best Medical Clinics which has ever been published

MILTON PLOTZ

Adjustment to Physical Handicap and Illness A Survey of the Social Psychology of Physique and Disability By Roger G Barker, Beatrice A Wright, and Mollie R Gonick. Octavo of 372 pages, illustrated. New York, Social Science Research Council, 1946 Cloth, \$200 (Bulletin 55)

We can hardly do justice in a short review to the tremendous effort and excellent presentation of the work of the authors. Their evaluation of the relationship of various disabilities to psychologic attitudes of those afflicted is thought-provoking. One might wish that they did not use the term "crippling" and "crippled persons," but one has to commend the authors on this worth-while presentation of a subject which deserves our closest attention, especially at this time when most of us are, in one capacity or another, treating disabled veterans. It is a timely addition to the literature in the field of social science.

JOSEPH L ABRAMSON

Roentgen Interpretation By George W Holmes, M D, and Laurence L Robbins, M D Seventh edition Octavo of 398 pages, illustrated Philadelphia, Lea & Febiger, 1947 Fabrikoid, \$700

A worthy successor to the previous editions of Holmes and Ruggle's Roentgen Interpretation, this text book, now in its 7th edition, has been well recognized for the past twenty-eight years. Dr Laurence L Robbins, who has succeeded Dr George W Holmes as chief of the department of radiology of the Massachusetts General Hospital, brings to this edition the more recent advances in diagnosis and treatment, thus maintaining its high standard

Students of medicine might well include Roentgen Interpretation in their library as one must recognize, as did the authors many years ago, that without a knowledge of radiology one's medical education is indeed wanting. The book is informative, thorough, and contains not only tables for comparative studies of allied lesions, but also a very complete bibliography permitting the student greater entree into this relatively new branch of medicine

MILTON G WASCH

Quantitative Clinical Chemistry By John P Peters, M D, and Donald D Van Slyke, Ph D Second Edition "Interpretations" Volume I Octavo of 1,041 pages, illustrated Baltimore, Williams & Wilkins Company, 1946 Cloth, \$700

This is a review of the first volume of the second edition of Peters' and Van Slyke's great work. Although the original edition was issued in two volumes, one on *Principles* and one on *Methods*, the second edition is being expanded into three volumes. The tremendous increase in important material which Dr Poters had added has necessitated his presenting the section on *Principles* in two volumes

The first part deals with carbohydrate and is divided into three large chapters, first on chemistry, then physiology, and finally clinical applications. It is most complete and is scholarly written. The author's arguments against the use of insulin without glucose in the treatment of diabetic acidosis are good. His description of so-called alimentary glycosuria is not much different from mild diabetes.

It is undoubtedly the most important book on the subject. The clinician will do well to use this as a reference book, for it provides a fine chemical and functional basis for the understanding of many diseases in medical practice.

WILLIAM S COLLENS

The Drama of Sex. By James Lincoln McCartney, M D Octavo of 147 pages, illustrated New York, Stratford House, 1946 Cloth, \$2 50

This book has been prepared by an authority with an excellent psychiatric background. Its failing, one which books of this type usually have, is that it gives too much attention to the details of the sexual act. It probably would be too stimulating to anyone in early sex life. A mature physician will appreciate its value.

BERNARD SELIGMAN

Calcific Disease of the Aortic Valve By Howard T Karsner, M D, and Simon Koletsky, M D Octavo of 111 pages, illustrated Philadelphia, J B Lippincott Co, 1947 Cloth, \$500

This is a very handy book of reference which covers the pathology of aortic stenosis quite completely and the clinical features adequately. It is so common for calcific disease of the aortic valve to be considered in differential diagnosis and also so common for a certain amount of confusion to be expressed about its clinical signs and symptoms, that this volume should prove useful indeed

ANDREW BABEY

Medical Addenda. Related Essays on Medicine and the Changing Order By The New York Academy of Medicine Committee on Medicine and the Changing Order Octavo of 156 pages New York, Commonwealth Fund, 1947 Cloth, \$1 75

This is a series of eight essays on present trends in the social aspects of the practice of medicine. The poorly chosen title gives little clue to the nature of the essays which supplement and round out the New York Academy of Medicine's monographs on Medicine and the Changing Order. Reading this little book will not only give the physician some idea of the nature of the problems facing him today but will restore his pride in belonging to a profession with so many opportunities for dedication and service to the community

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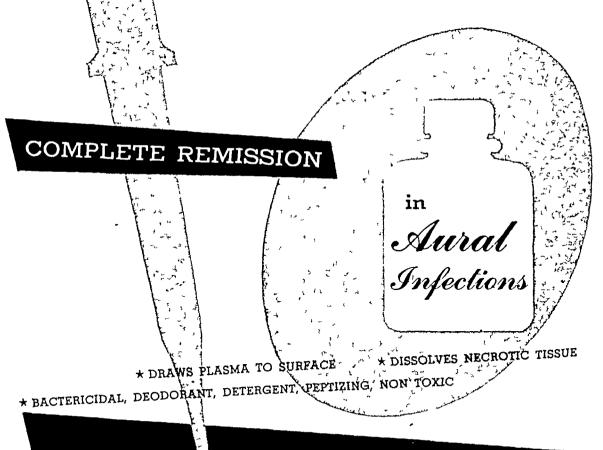
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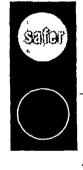
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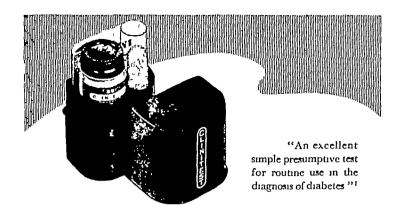
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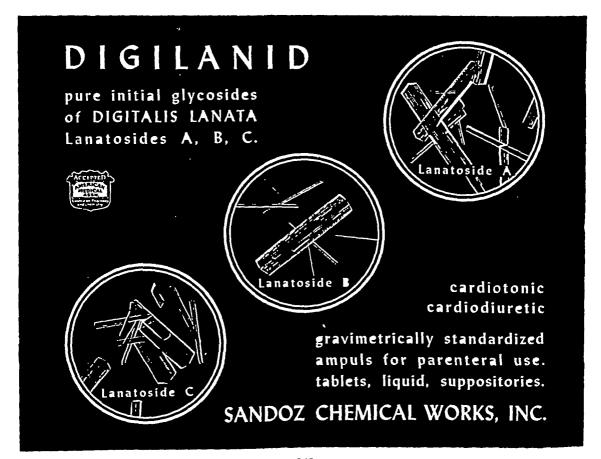
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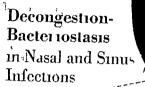
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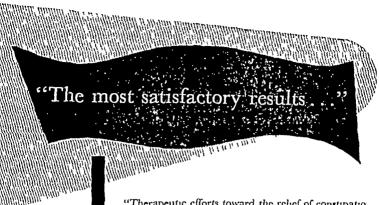
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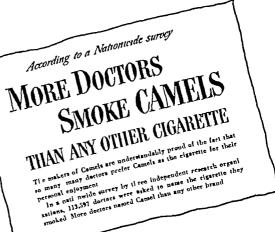
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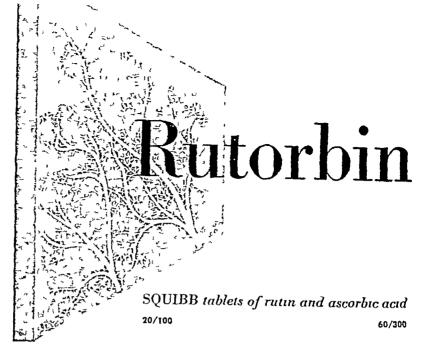
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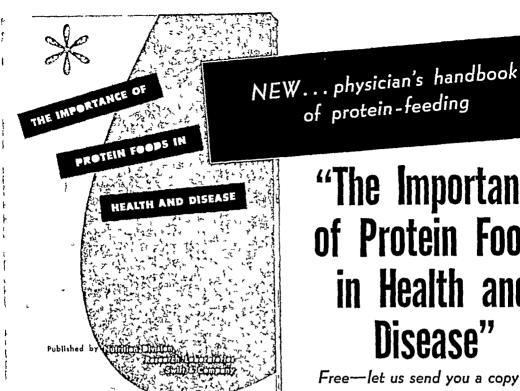
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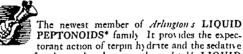
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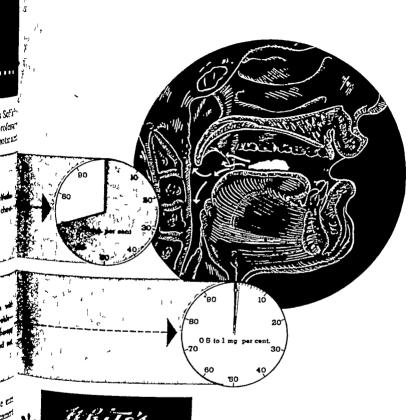
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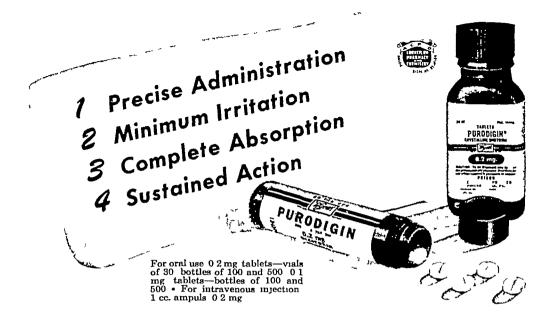
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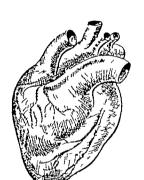
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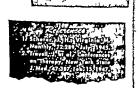




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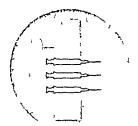
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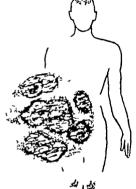
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1 Bauman L.: Bull New Eng M. Center 5:17 (Feb.) 1943.





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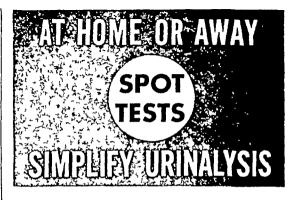


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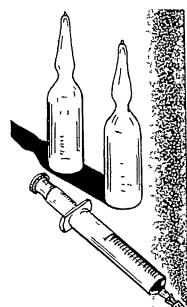
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*Fishberg, A. M.: Heart Failure Lea and Febiger Philadelphia 1946 p. 733





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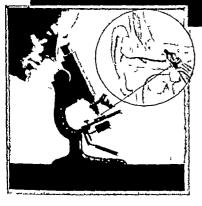
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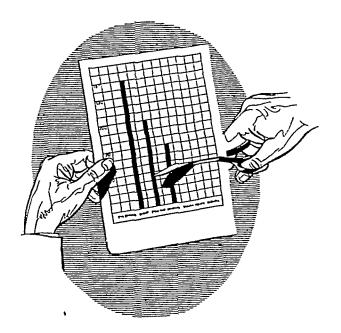
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Editorials

Plain Talk, III

Right now is a good time to do some in tensive thinking. This country, the USA, is assuming responsibility for large loans to European nations. It is supporting itself and pouring foodstuffs, clothing, and other aid into Europe, Asia, and the Middle East. The result necessarily will be increased living costs in this country as long as the laws of gravity and supply and demand remain operative twenty-four hours a day. One may have his cake and eat it, too, only in Utopia

The profession of medicine at least since it has been on a sound scientific basis, has been taught to be realistic. It has been realistic with relation to the art and science of medicine, and is now. But the profession lives as a minority group within the larger body politic and is subject to the fluctuations of the national economy. It will be in creasingly subject to political pressures as living costs rise as they must. Cheaper medical care will be sought by the tax-ridden public and will be dangled before the voters, in the form of government-controlled medicine by politicians seeking re-election.

Bismarck in Germany started the game Lloyd George in England played it after World War I. Mr I Falk in the Bureau of Research and Statistics in the Social Security Board has been urging it on this country for years Organized medicine in the United States has been under political attack as a "softening up ' preliminary since 1933, and such media as the medical and hospital provisions of the W M-D bills have been used in Congressional committee hearings heavily weighted in favor of socialized medicine to propagate the idea through publicity Federal "health workshops' sponsored by the U.S.P.H.S were used as propaganda media in support of the National Health Program of 1946

A little of the realism displayed by individual medical men in carrying on their science and art of medicine in studying this politico-conomic disease of propaganditis seems in dicated. The A M A and the various state and county medical societies have been studying it exhaustively and have furnished individual medical men with factual studies.

reports, and suggestions that individual doctors familiarize themslves with the seriousness of the situation

To those who consider the plight of the nations in Europe which have adopted tax-paid, government-controlled medical service, it must be apparent that *propaganda* for the adoption of such measures is an early symptom of the disorder of national bankruptcy, and that acceptance of the scheme is the dis-

ease itself. All Europe has it. We here are in the propaganda-for-state-medicine state as yet. It is a warning that with inflation, rising prices, and the febrile hysteria of an election year coming on, the easiest political nostrum to offer to the public would be cheap state medicine. Doctors will not be fooled. They will recognize it for the bankruptcy it really is, whatever you may choose to call it.

Inflation and Medical Costs

Some say we shall have inflation, others say not necessarily, still others say we have it now. To doctors this is apt to be confusing. After all, their job is to care for the sick and the question of inflation has a bearing on how they shall do it.

In 1948, political campaigns may be expected to produce possibly more than the usual election year quota of weird schemes to cure rising costs of living. These schemes, of course, will touch upon medical care. Our esteemed contemporary, the Saturday Evening Post, says, editorially, in part ¹

Despite the differences in detail, all these electoral squirmings have one common factor-namely, the disposition of peoples the world over to expect too much of politicians in The fault, of dealing with economic events course, is with the politicians, who have resorted to the most preposterous quackery to persuade the public that their snake oil would cure anything from inflation to the housing shortage Governments everywhere have undertaken to carry out nonfulfillable promises by plunging into the economic field and making a horrible mess of things This was prophesied almost a century ago by John Stuart Mill in his monumental Essay on Liberty, wherein he

"The public, expecting everything to be done for them by the state, or at least to do nothing for themselves without asking from the state not only leave to do it but even how it is to be done, naturally hold the state responsible for all evil that befalls them"

It seems useless to belabor the politicians, as the *Post* points out, they cannot perform economic miracles On the other hand, they

cannot stand around and let things drift along Inaction in the presence of rising costs of everything from shoe laces to medical care is no way to please the customers in an election year. The boys with the ballots want action and plenty of it. So the politicos give and hope for the best

However, (continues the *Post*) instead of concluding that the state is out of place in fixing prices or building houses, the voters are more likely to blame the political party in power and to install some other political party. The successful faction, instead of interpreting its success as a directive to let nature take its course for a few minutes, usually introduces some quackery of its own, explaining the failure of its opponents as due, not to quackery per se, but to the wrong brand of quackery Thus, unless common sense comes to the rescue, there develops a contest between charlatans which can end only in some sort of totalitarian seizure of power

The outlook seems grim, but there is a loophole—that common sense which the Post invokes. It has survived assorted disasters, election promises, prohibition, and numerous booms and depressions. We believe it will come to the fore now if given the opportunity.

Of course this country cannot escape the economic consequences of the recent war, nor can it or should it evade the issue of its postwar commitments to the less fortunate people of the world That is common sense

If such common sense results in higher prices here, that is to be expected, we can't have our cake and eat it, too Nor can we require the politicians to pull economic

¹ December 13, 1947, p 156

rabbits out of their hats But it is hoped that in the forthcoming turmoil of debate our American system of medical practice will not suffer the fate that befell the profession in England after World War I

We haven't a doubt that socialization of medical practice will be proposed seriously as a measure of economy, but we reiterate our belief that the common sense of the American people will reject such a measure on the ground that, though it would spread the costs of medical service without question, it would add servicely to the total costs and so dilute the service as to make it, in the long run uneconomical and distasteful to the people of the nation

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Current Editorial Comment

Unlawful Practice of Medicine In the Court of Special Sessions in the City of New York recently a man was convicted and sentenced by the presiding justice The charge was the unlawful practice of medicine Certain of the remarks of the presiding justice as excerpted from the

minutes are of interest

"This case," he said, "has given the court a great deal of concern. Your counsel has seen fit (and properly so) to refer to the fact that a large number of letters have been received from all parts of the country in your behalf. I am afraid that a great number of those who wrote letters are acting under a very serious misapprehension. They seem to believe that the judges are the makers of the law, that it is up to the judges to approve the work that you did

That is not our function at all We didn't institute this proceeding. It was instituted by the duly authorized proper official, the State Attorney General, who brought the case before this court, which has jurisdiction, and you came on for trial and witnesses were called to the stand and, after being sworn, they gave testimony which this court has declared to be over whelming in substantiating the charge that you practiced medicine without a license. That is how simple it is

"This court doesn't make the rules with regard to the permission of men to practice medicine. That is done by the State Legislature. A man may be a very, very keen personality and feel that he can plead the cause of the downtrodden and the in digent, or the unlettered, or the untutored, but unless he passes the bar examination and is admitted to practice, he has no right to plead. Not that he might not be an ideal practitioner if he fulfilled the legal requirements. Very often that happens to be the case.

"So, you see, it is not our province to pass on naturopathy or chiropractic practices. That is not our function at all Whether we like it or whether we don't like it is beside the issue. We merely have to apply the laws that have been laid down. That is the function of a judge. The moment he begins to give vent to his own personal feelings, in my humble opinion, he is no longer a judicial officer. Let him go to the Legislature.

"Now, if there is something wrong with the legislative enactment with regard to the practicing of medicine in this state, the place to cure it is in Albany Until there is a law giving sanction to what you did, what you did becomes violative of the law as it

now exists

'I go back again to these letters for just a brief comment Frankly, you caused a notice to be sent out to your friends and to your acquaintances I don't think there is anything reprehensible about doing that When a man is in trouble, he has a right to call on all and sundry to come forward and testify either in person or by some other method of communication, on the behalf of the man who is in trouble. Those letters have been most laudatory, in the main But on the other hand, there have come letters that you did not solicit, which reprimand you, which condemn you, which blame you for ill health, suffering, and unhappiness We can't judge, therefore, on letters

'You may have treated people whom, by virtue of your personality you have been able to impress, and so they come forward at this time to help you But there have been other people who claim that when they came to you with a serious allment your treatment resulted in their almost annihilation. There is no proof of these things, so we are not going to give them

The man who wrote against you is not before us as a witness The man who wrote in your favor is not before us as a And so, while in numbers those who wrote in your favor outweigh those who didn't, the letters condemning you are strong in their very content—dates, doctors involved, x-rays ready to be submitted, things of that kind

"You have been subjected to the same treatment as any other defendant convicted after a trial. An investigation has The judges didn't participate been had in the investigation. It was done by the same probation officers who take care of all

cases coming to this court

"And what do we find upon reading the report? We find that, in truth and in fact, you have set yourself up above the law You are so convinced about your own powers, and your own right to carry on in the fashion that you choose, that you have decided that you can snap your fingers at the law and let it go at that The law says you mustn't use a stethoscope You did The law says you mustn't make the examination which the record reveals you did, but you did

The defendant had had a record of three previous arrests charged with practicing medicine without a license (At a previous trial the presiding judge had warned the defendant "You must desist from practices which have not the blessing, if you wish to call it that, of the law, in other words, practices which at the present time are declared illegal That is one absolute Then, having that in mind and including that as part of the sentence in the way in which I shall point out, the sentence of the court is that you pay a fine of \$500 and that you be imprisoned in the Monroe County Penitentiary for a period of six months Since this is your first offense—the first conviction and, so far as I am concerned, the first offense—I am impelled to a hope that I am using some leniency when I suspend the operation of the penitentiary sentence, but that is only in the belief and upon the express instruction that you desist from the unlawful practice of medicine That is all "

(In spite of lemency previously shown to him by the former court, the defendant persisted in carrying on his illegal practices)

Continued the presiding justice "Now you chose to disregard that injunction don't know the judge who said it, but that is what the police record reveals You chose

to continue what the law condemns you were hailed into this court and we found

you guilty

"The task of sentencing any man is the most unpleasant feature of this entire court's function It isn't easy It takes great deal of responsibility, worry, aggravation, fretting We don't eat our lunches any better when a man goes to jail We have to be mindful of the fact that while he has done wrong, he is not totally wrong. there are some good things about him And there are some good things about you

"We are here, however, to uphold the law and to protect the public. The public has a right to say What are you there for? The law was pointed out to you judges as on the This man has been convicted bebooks fore He saw fit to disregard the injunction of the judge Who are you (the public would have a perfect right to say) to disregard that history? And so, you see, it isn't a matter of our choice. It is a matter

of our duty "The law says, when a person is dying, the only one that the law allows to touch that person, diagnose or treat that person, is a licensed physician The record shows that medical science can't cope with every problem They have much yet to learn But the law says, at least they have the required courses of study, they have made themselves ready to practice the art of medicine, and the law says Do with this dying person as best you know how, but you, the licensed doctor, shall be the only one

"Now, the law never intended that that dying person should go to you or be allowed to be treated by you If that were the law, we would have dismissed the charge law says you can't do it, and you mustn't And I tell you again, it is the Legislature that has made that law, not the

judges

"By a majority of the court the defendant is sentenced to the New York City Penitentiary for a period of one year I dissent and vote six months in the workhouse"

We quote extensively from the record in this case to illustrate some of the difficulties in obtaining a verdict of guilty on what seems to be a simple matter of proving that someone was practicing medicine without a license

In this instance the defendant had been previously warned to desist, had been fined \$500, and had had his jail sentence suspended Yet he continued, in spite of lemency shown him, to break the law

sentencing by the presiding justice is such a masterpiece of clear statement that every member of the Society is urged to read it carefully

A.M.A President Looks Ahead In his opening address President Edward L Bortz, M.D., of Philadelphia told the House of Delegates of the American Medical Association at their recent meeting that "it is high time that organized medicine play a larger role in preparing the members of the profession and allied groups for rendering an emergency medical service in time of need

"The development of atomic energy as an industrial project," he said diately forces upon the medical profession the necessity of a clear understanding of the hazards which attend proximity to radioactive substances which are now being

claborated in great quantity

"An appreciation of these dangers and an understanding of protection against them, and also of management of casualties, represents one of the most important challenges

facing medicine

The AMA, president, urging wholehearted cooperation between the medical profession and the US Atomic Energy Commission, read a statement from Shields Warren, Interim Director, Division of Biology and Medicine US Atomic Energy Commission, The Washington, statement read

The increasing use of atomic energy and its outstanding peacetime products, the radioactive isotopes, are the most important developments in research since the inven tion of the microscope They promise to unfold new technics that will demand the highest degree of scientific imagination and skill for full exploitation The responsi bility of the medical profession for the full and prompt exploration of the new fields is clear and pressing

As in any new field, hazards as well as benefits exist, potential dangers to investi gators their patients, and the general public from the use of radioactive isotopes dictate that the medical profession is also respon able for the prevention and recognition of

these dangers

'The unprecedented scale of durangements that would result from an atomic ex plonon presents a new and vital responsi bility to the medical profession

medical organization to handle effectively these aspects of such explosion should be in existence and such plans should be at a con tinuing high level of readiness

"The Atomic Energy Commission is destrough that the medical profession shall explore all possible avenues by which the beneficial effect of atomic energy may be used to aid mankind, and that the medical profession shall take the necessary measures to protect mankind against radiation and other hazards which may exist in the field of atomic energy "

Dr Bortz in his report touched on vari ous activities of the American Medical Association which have been undertaken since the A.M.A centennial meeting in

Atlantic City last June

Dr Bortz said in part

While the physician today is a more effective agent in behalf of the health of his patients and in the support of public health measures than at all previous times in the history of our country, an additional re-sponsibility now must be assumed We must accept leadership for the consideration of various plans that will furnish acceptable medical care to those members of communities who are, for various reasons, at one time or another unable to meet completely the financial demands for such care No answer is yet available for all the variations of this problem In the meantime, the experimental method should be followed under local and controlled conditions Pilot studies can be carried on over a span of several years in communities as in labo-From time to time an accounting of accomplishments, and a reconsideration of detriments, should aid in the final solu-Obviously no one tion of the problem plan can be a solution for all portions of the population of our great nation | Flexibility and adjustment to community needs is in order

It should always be kept in mind that compulsion is an odious term, and taxation is not ordinarily interpreted as insurance In setting up any plan therefore, it is im portant that accurately descriptive terms should be employed by all concerned our Congress is in session it is our responsibility to see that the folks back home in struct their representatives concerning the importance of maintaining the democratic approach to the solution of our social prob Let s be awake to the challenge and find in it a means to a higher level of medical service

The President's Page

THE DUTIES of the President of the Medical Society of the State of New York require among other things, that the President attend each of the eight District Branch meetings

While in attendance at these meetings, I had an opportunity to speak with many of the officers and members of the various county societies, and one of the conclusions forced upon me as a result of these conversations is that each county society should, if it has not already done so, establish haison with various lay groups within the community. One of the best methods I know to accomplish this result would be for the president of each society to appoint a Committee on Public Education. The purpose of this committee would be to provide for the establishment by each county society of its own speakers' group, and thereby make available at all times a roster of doctors who are prepared to talk on subjects pertaining to medicine in any of its social, economic, or political aspects. These doctors should be prepared to speak either on their own initiative or at the request of any of the various lay groups within the community.

Public education is the most important single thing any county society can accomplish I can think of no better way in which the county society can achieve this than for the Committee on Public Education first to train and then make available speakers who can give our profession's views on such timely topics

We believe in the private practice of medicine as the proper way to deliver medical care. For certain aspects of medical care, public funds are available. If we are to protect the system of private medical care—if we are to insure proper allocation and administration of public funds—then the county society must provide leadership. Otherwise, the public will turn elsewhere for it

For these reasons, I believe the establishment of a Public Education Committee is most important. If this committee can find a number of adequately trained men who will go out and discuss these topics, the speakers will so establish the local county society in the minds of the public that the people, and as a consequence both State and local legislators, will automatically turn to the Society for the answer to any medical problem. Likewise, it will turn to it for help in finding a solution to any social, economic, or legislative question that touches upon our activities as members of the medical profession.

Should you desire any information or assistance in planning the creation of a Committee on Public Education and Speakers' Bureau, I suggest that you contact our field representative, Mr Thomas E Walsh, of the Public Relations Bureau at the State Society's office, 292 Madison Avenue, New York City 17

Louis H Bauer, M D President

Scientific Articles

TRANSPLANTATION OF THE EXTENSOR CARPI LILNARIS TO GIVE ABDUCTION OF THE THUMB

MICHAEL BURMAN, M.D. New York City

(From The Hospital for Joint Discuses)

I HAVI devised an operation in which the tenplanted through the sheath of the abductor longus pollicis to give abduction to a thumb The kinetics of the thumb are analyzed to make the proper indication for this operation

Kinetics of the Normal Thumb

The normal thumb is balanced-balanced muscles moving joints, balanced by pairing The carpometacarpal joint pairs in movement of the thumb with the metacarpophalangeal joint (proximal pairing) and the latter joint with the interphalangeal joint (distal pairing)

The direction of movement of each joint of a pair 15 sımilar Try to oppose the thumb when the metacarpophalangeal joint is extended nor can the metacarpophalangeal joint of the opposed thumb be fully extended. This dissociation of joint motion is noted in the spastic thumb

The range of movement is not equal in each joint of a pair The metacarpophalangeal joint which interlocks each pair has a losser range of motion than either the interphalangeal or carpo-

metacarpal joints

Fixation of one joint of a pair limits motion of its mate. Stabilize with your fingers the carpometacurpal joint of the thumb and see how little motion is allowed in the metacarpophalangeal joint. Hold the metacarpophalangeal joint The movement of the interphalangeal and carpometacarpal joints is less. So, too is metacarpophalangeal joint motion restricted when the inter phalangeal joint is held (Pairing motion is lost when one joint of a pair is stiff or when its motor (the tendon or muscle moving it) is gone strain the active joint by hand or splint after the reconstructive measures of arthroplasty or tenoplasty to give the handicapped joint chance to regain commensurate motion)

The proximal pair of joints serves lateral movement of the thumb the distal pair the movement of flexion-extension of the thumb

The carpometacarnal and metacarpophalangeal loints pair in opposition as they do in the opposite

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inovement of extrinsic abduction 1. When the finger or thumb moves by muscles whose origin and insertion begin and end in the hand, such power is intrinsic. If the muscle begins in the forcarm and ends in the hand or its digits it is an extrinsic muscle giving extrinsic power Adduction of the thumb in the plane of the hand by pull of the oblique and transverse adductors (intrinsic adduction) is balanced by the extrinue long abductor and short extensor of the thumb The extensor longus pollicis is an adductor of the normal thumb

Abduction of the thumb is antigravitational adduction gravitational The greater range of motion in either abduction or adduction is in the corponetacarpal joint, an active movement in abduction and a passive one in adduction Lateral motion of the metacarpophalangeal ioint is very slight, and the extended thumb moves as a rod when the first metacarnal is Adduction of the flexed thumb is adducted namful and restricted so too is extrinsic ab-The balancing movement to opposition or adduction of the thumb is abduction When the thumb is brought into abduction from adduction the long abductor contracts a little more strongly than the short extensor in the beginning of movement Similarly power of the short extensor is a little greater when the opposed thumb is brought out of the

The abductor longus policis and extensor brevis pollicis lie in the same sheath. One can not move without the other (synchrony of action) The tendons and at different levels to make pairing of the carpometacarpal and metacarpophalungeal joints mandatory Metacarpopha langeal joint motion is balanced by proportionate power between the flexor brevis pollicis and the extensor brevis pollicis while the interphalangeal joint is moved by the flexor longus pollicis and the extensor longus pollicis. The metacarpophalangeal and interphalangeal joints pair for effective flexion or extension of the thumb Thus, there are four groups of balanced muscles in the thumb powering two systems of paired joints

Wrist Position and Function of the Thumb

As there is a position of the wrist in its slight dorsifiction in which finger power is strongest, so is there a similar position of the wrist for most efficient use of the thumb. The use of the thumb is good when the wrist is neither ulnarly nor radially deviated. The long abductor is stretched in adduction of the wrist and is shortened when the wrist is abducted. Effective abduction of the thumb, however, is least in this latter position of the wrist. My right thumb can be abducted 7 inches in the neutral position of the wrist, 6 inches in ulnar adduction, and 5½ inches in radial abduction.

Opposition of the thumb is good in the wrist which is balanced laterally. It is not good in the radially abducted wrist, because the shortened long abductor tendon stops the thumb from entering the palm. Opposition is excessive in the adducted wrist. Similar observations are made in the use of the thumb when the wrist is placed in excessive volar flexion or dorsiflexion, the anteroposterior relation of the wrist to the thumb as compared with the lateral relation. The most useful position of the wrist is the Jones position of mild dorsiflexion.

In volar flexion of the wrist the thumb opposes and abduction is poor, because the insertion of the long abductor tendon is placed more volarly. In dorsiflexion of the wrist heyond the neutral position, opposition of the thumb is poor, and abduction of the thumb is favored, since the tendon insertion is placed more dorsally.

The obiquity of the scaphoid makes wrist movement oblique. When the wrist flexes volarly, it adducts at the same time, or when it dorsifieres, it abducts a little. Therefore, in a dyskinetic situation, volar flexion deformity and ulnar adduction deformity of the wrist are associated, the thumb falling into the palm to favor its opposition and hinder its abduction. The reverse deformity is uncommon.

The neutral position of the wrist gives best use of fingers and thumb The thumb (or fingers) should not be operated until the neutral position of the wrist is assured

Case 1—A Bunnell operation was performed to overcome the paralytic flat thumb of a twenty-seven year-old man. The wrist showed fair power with dominance of the radial extensors, so that fusion of the wrist was not advised. An opposition contracture following operation was slowly resolved by exercise. He could form an "O" and hold a small marble with thumb and index finger, but the dorsifiexion and abduction position of the wrist did not allow a more powerful use of the thumb

Kinetic Disturbances of the Thumb

The use of the thumb is changed when its muscle or joint balance is broken by any one of the four acquired forms of hand disability traumatic, arthritic, spastic, and paralytic deformities "3

The intrinsic and extrinsic deformities of the thumb are caused by disability in the distal pairing system of joints. In the intrinsic deformity, the thumb is flexed at the metacarpophalangeal joint and extended at the interphalangeal joint. The thumb usually is opposed, since the carpometacarpal joint moves with its fellow joint. The extrinsic deformity is the reverse deformity the metacarpophalangeal joint is extended, the interphalangeal joint flexed, and the carpometacarpal joint abducted.

The deformities of the proximal carpometacarpal and metacarpophalangeal joint system are twofold, based on disturbance in the relation between opposition and abduction, and between adduction and abduction. When the thumb is held adducted in the plane of the hand by contracture (abduction contracture of the thumb), as it often is in all the groupings of hand disability, abduction spread of the thumb and opposition are limited. The contracture is released by stripping of the first dorsal interosseous muscle and section of the combined tendons of insertion of the adductores transversus and obliquius muscles.

Opposition position of the thumb is due to an imbalance of power in favor of the thenar muscles. It is seen in the spastic hand and often in the hand of Erb's palsy. Opposition contracture is uncommon, although I have seen it in the hand of Volkmann's contracture and after the Bunnell operation.

The effort to abduct the thumb by compensatory extensor longus pollicis action is concentrated either on the metacarpophalangeal joint or the interphalangeal joint. A hyperextension deformity of the metacarpophalangeal joint with volar subluxation of the metacarpal head is often seen in the spastic hand. The movement of abduction after the transplantation of the extensor carpi ulnaris may be assisted by this overaction of the long thumb extensor.

Deformity in opposition of the thumb is sometimes associated with an adduction contracture in a plane forward to the hand. The release of deformity may require combined adductor release and thenar stripping. The reverse deformity, usually a paralytic one, is the abduction contracture of the thumb (flat hand deformity) for which opposition-giving operations have been devised, notably, the Bunnell procedure

Transplantation of the Extensor Carpi Ulnaris Muscle

No satisfactory operation to abduct the thumb seems to have been devised. Don'd noted that Hoffa shortened the extensor longus politicis This operation is comparable to the tendon transplantation of Biesalski and Mayer in which the extensor indicis propries is attached to the long extensor of the thumb Hoffa transplanted the flexor carpi radialis to the extensor longus pollicis to secure active abduction of the thumb and for the same purpose shifted this tendon to the abductor pollicis longus together with one half of the extensor carps radialis

Foerster and, later, bilfverskiöld performed a tenomyotomy of the muscles terminating on the ulnur sesumoid of the thumb, or a myotomy of the opponent policis. The adductors seem to have been cut also. This operation is comparable to the operation of thenar stripping which I described in 1938:

The transplantation of the extensor carpi ulnaria supplements adductor release and thenar muscle stripping operations which only lessen deformity. It is a positive operation since it gives extrinsic abduction to a thumb which has none. (This muscle also may replace the other oblique muscles of the dorsal part of the forearm)

The replacement of the long abductor of the thumb is needed to restore kinetic balance The thumb may now be withdrawn from the palm to allow grasping and the replacement sta bilizes the base of the thumb to give better oppo-Pition

The operation is performed under tourniquet control, using the pneumatic tourniquet or blood pressure cuff about the arm An Esmarch bandage around the ficshy part of the forearm should not be used, for the forearm is often short as it is in Erbs palsy The Lemarch handage blocks the proximal freeing of the

extensor carpi ulnarıs muscle

The first longitudinal meision which is I inch long with the base of the first metacarpal at its center exposes the long abductor tendon at its inscrtion The tendon is split in the line of its fibers. A trap door of bone is lifted from the base of the first metacarpal bone and the leaf of bone turned back distally (Fig. 1) The second long. tudinal incision begins mut distal to the base of the fifth metacarpal bone (the insertion of the ex tensor carpi ulnaris tendon) and runs along the course of the muscle The tendon may lie more ulnarly, since the wrist is usually adducted and volarly flexed The tuberosity of the fifth meta carpal bone should be used as a guide so as not to mistake the thinner extensor tendon of the fifth finger for the extensor carpiulnaris tendon (Fig 2)

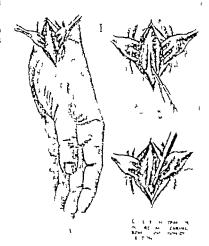


Fig 1

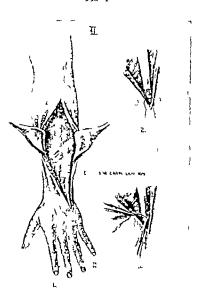


Fig 2

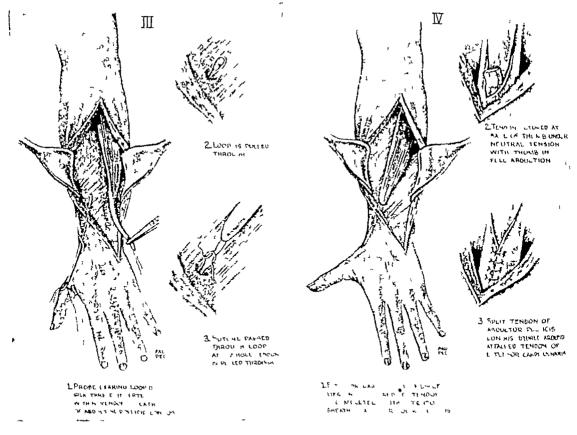


Fig 3

A loop of black silk is then passed through the sheath of the long abductor tendon from below with the eye of a small probe carrying the loop. The probe with the loop emerges through the fascia at the proximal pole of the sheath. This opening is enlarged to a diameter of one-half inch to allow the later passage of the transplant. The probe is withdrawn, leaving the loop in place proximally.

The insertion of the extensor carpi ulnaris tendon is freed by a transverse incision and the fixation suture passed through it. The tendon end is made conical. The tendon is freed along its full length with enough of the muscle belly being dissected free to give a straight line of pull (Fig. 3).

The tendon is transplanted by using the silk loop to pull it through the sheath of the abductor longus pollicis. The conical tendon end is fed into the hole made in the fascia. Since the space through which it passes is small, it is sometimes difficult to pass the tendon, especially, if the adjacent tissues have been scarred by previous operation. The passage of the long peroneal tendon is made more easily in the foot, since there is much more room in the sheath of the

Fig 4

tibialis anticus The tendon is passed without twist and is anchored under neutral tension beneath the bone flap in the first metacarpal bone, the thumb being held in wide abduction in the plane of the hand (Fig. 4)

The transplant is just long enough to reach to the base of the first metacarpal. In only one case was it too short, the Esmarch bandage stopping the further proximal freeing of the muscle belly of the extensor carpi ulnaris, the transplanted tendon was sutured, therefore, to the tendon of the long abductor just below the radial styloid.

The muscle belly of the transplant is subcutaneously placed and lies on the outer surface of the deep fascia. Its tendon is entirely intrathecal, so that it is unnecessary to construct a gliding surface as Mayer does in the peroneal transplant. The muscle should not be passed under the fascia

The fixation suture is either silk or No 1 chromic catgut. The two strands are passed through the eye of a heavy, short, curved needle and the suture taken through the bone at the base of the trap door. The two threads are tied to each other over the bone flap. Three

other interrupted sutures are taken between the split halves of the abductor tendon and the trinsplant. The long wound in the forcarm is closed before the transplant is anchored.

The thumb is immobilized by plaster in abduction for three weeks when physical therapy which should include sinusoidal stimulation of

the transplant is begun

This operation alone may be performed or it may be performed in conjunction with osteolomy of the radius to overcome supination contracture of the forearm or fusion of the wrist. The loop should be passed through the sheath before the bony operation. A window is cut in the plaster three weeks after operation to stimulate the transplant.

The extensor carpi ulnams was transplanted in one case to give power to the paralyzed extensor policis longus. It was passed through the sheath of this tendon and sutured to it below the level of the winst since the transplant is too short to reach the distal phalanx of the thumb

I did not suture the transplant to the short extensor tendon deliberately, although I probably did it inadvertenth. Do it if the thenar muscles are strong in order to avoid that dissociated position of the thumb in which the metacarpal is abducted and the thumb is in the intrinsic position

Use of Transplant

The use of this transplant in the four groupings is now described

A differentiation should be made between the stretched abductor and the palsied abductor of the thumb

The wrist flexes volarly and adducts ulnarly when the extensores carpi radialis longior and brevior are paralyzed, as they may be in spastic or infantile paralysis. The abductor longus pollicis cannot abduct the thumb because it is stretched. The thumb shows an adduction contracture in a plane a little forward to the palm if the thenar muscles draw it into the palm or a flat hand deformity if the thenar muscles are paralyzed.

The extensor carpi ulnars is not transplanted to a stretched abductor longus policis. It is attached to the radial extensor tendens of the wrist to give it lateral balance if the patient is too young for a wrist fusion.

The Spastic Hand—The thumb of the spastic hand is drawn into the paim. The abductor longus pollicis is either stretched or paralyzed. The extensor carpi ulnaris is used to replace the paralyzed abductor longus pollicis. A stripping of the thenar museles or adductor section should be performed at the same time to overcome contracture.

Case 2—(Abductor palsy in a spasiic hand)—A girl of thirteen with a right-sided homiplegia had a pronated forearm with the wrist volarly flexed and adducted and the thumb indrawn. There was a moderate degree of plastic muscle rigidity.

Fusion of the wrist using a tibial bone graft was performed on March 5 1915 Release of the spantic adduction contracture of the thumb and intrasheath transplantation of the extensor carpi ulnaris

tendon were performed on July 8, 1945

She is able to keep the thumb out of the palm and to hold things between thumb and fingers. The period of postoperative observation is a year and a half. The girl and her mother are well satisfied. She still hyperectends the thumb at the metacarpo-phalangeal joint as she did before the operation a substitutionary motion which helps the transplant.

Case 3—(Abductor stretching by palsy of the radial extensors of the terrist)—A boy soven years old had a left hemplegia in which the left wrist was deviated uliarly and bent volarly by paralysis of the radial extensors. The indrawn thumb was held in mild adduction contracture. It could not be abducted although the long abductor had some strength, Finger power in extension and flexion was good. The procedures indicated were the release of the adduction contracture the stripping of the thenar muscles and the transplantation of the extensor carpi uliaris tendon to the extensor carpi radialis longor and brevior tendons.

The Paralytic Hand—There are two types of paralyted hands which come under this heading the hand of infantile paralysis and the hand of Erb's palsy

The hand of infantile paralysis has the thumb lying in the plane of the hand (flat hand) through the action of the intact long abductor, for the thenar muscles are paralysed

The indication is not the replacement of the long abductor but the replacement of thenner muscle power. This is done by the Bunnel operation using the flexor carpi ulnaris muscle as the motor. There are other operations such as those devised by Steindler Royle Ney etc., which are sometimes used. Capsulotomy of the carpometacarpal joint with or without adductor muscle section, or rotational esteotomy of the bone of the first metacarpal is done at the same time as the Bunnell operation to give free passive opposition of the thumb

This is the usual state of things. The more unusual situations, such as paralysis of all thumb muscles paralytic club ulnar hand and indrawn thumb demand special procedures to give stability of the thumb.

If all the thumb muscles are paralyzed a bone strut operation is performed the piece of bone being placed between the first and second metacarpal bones so that the thumb is held in the neutral or relaxed position. Case 4—A transverse bonc strut was placed between the first and second metacarpals of the paralytic right hand of a girl of seventeen on September 7, 1944—The only power in the hand was that in the flevor sublimis of the ring finger—It was felt that the use of the tendon to give opposition of the thumb was unwise—The reverse procedure seemed better—to place the thumb for grasping and to bring the ring finger to the thumb

The strut operation was a final operation on the hand rather than an initial one. A fusion of the wrist had been done on November 29, 1943, and a flevor plasty of the elbow on February 7, 1944. The strut operation was followed by arthrodesis of the shoulder on September 26, 1944.

She has been observed for more than two years. The bone strut holds the thumb in excellent position, and she can hold an object between the rigid thumb and the movable fourth finger, which is the expected result.

'Paralytic ulnar club hand is caused by a weakness or absence of the radial extensors of the wrist with dominant power in the flevor and extensor carpi ulnaies muscles. The long abductor tendon is stretched

The wrist is stiffened so that it is placed in neutral position, and the thumb is then balanced. The extensor carpi ulnaris tendon is used to reinforce the radial extensors of the wrist if the patient is too young to stiffen the wrist.

Case 5—A boy of eight with a severe paralytic deformity of the left upper extremity showed, as one of the deformities, a great ulnar deviation (to an angle of 70 degrees) of the volarly bent wrist. The fingers were clawed and the thumb flat. The extensor carpi radialis and flevor carpi radialis muscles were quite weak.

The extensor carpi ulnaris tendon was transplanted subcutaneously on March 31, 1937, to the two radial extensors of the wrist. This operation was a substitute for wrist fusion

The angle of ulnar deviation was reduced from 70 degrees to 20 degrees by the extensor carpi ulnaris transplant. The unsuccessful use of the flexor carpi ulnaris as the motor (operation on October 14, 1938) to give opposition of the thumb further lessened ulnar deviation of the wrist.

The tendon of the flevor carpi ulnaris was attached to the distal and of the tendons of the extensor brivis pollicis and abductor longus pollicis which were divided about 1 inch above the wrist. The abductor was rated, according to the Boston system, as 3 before operation, for it was able to contract against gravity. The tendon of the short extensor was very small, being scarcely thicker than a thread, while the abductor tendon had good substance. The thumb fell quickly into the flat hand position by the action of gravity, even though the long abductor tendon had been cut. (It is wrong to use the stabilizing abductor as the transplant in the Bunnell procedure)

The patient could dorsifles the wrist actively on

February 11, 1945, but still had tendency to ulnar deviation of the wrist

There is also the very rare situation in which the thumb is indrawn by thenar power and the long abductor of the thumb is absent

Case 6—A man of thirty-four had a fial left arm. The posture of the extremity was unusual. The shoulder was internally rotated 90 degrees and abducted about 20 degrees. The elbow was held at 160 degrees. The forearm was hyperpronated to 135 degrees, the wrist volarly flexed and adducted ulnarly. The thumb was indrawn, and the fingers held in extension contracture at the metacarpophalangeal joints (Fig. 5)

The thumb had slight power in the abductor brevis pollicis and possibly in the flevor brevis pollicis, while the little finger had power in the abductor digiti quinti brevis. The only finger motion was strong (sublimis) flevion of the index finger. He could hyperpronate actively a little when the forearm was held at 100 degrees of pronation, and a muscle, presumably the brachioradialis, was seen moving on the dorsum of the forearm. Electrical muscle testing gave no response in the forearm musculature

The patient moved all the active muscles at the same time in a synergy which favored the develop-



Fig 5 Preoperative photograph October 21, 1946, showing hyperpronational deformity of the left forearm Thenar muscle power but no abductor power of his thumb (Case 6)



Fig. 6. A postoperative photograph (June, 1947) after a series of operative procedures which fused the left shoulder, derotated the forcurn, stiffened the wrist, and gave a little abduction power to the thumb by intrathecal transplantation of the radial extensors. The appearance of the extremity is good. He is able to hold an object between thumb and for finger ($Ca\omega$ 6)

ment of a hyperpronational deformity and the antigravitational deformity in this case, of ulnar adduction and volar flexion of the wrist. There was also direct relationship between the internal rotation contracture of the shoulder and the deformity of the forcarm in hyperproparation.

Operation was performed on November 11 1940: The index finger was manipulated to overcome the extension contracture of its metacarpophalangeal joint. The wrist was fused by the Abbott technic and the radius estectomized at its midpart by concentrotomy to bring the forearm into 90 degrees of pronation. The extensors carpi radialis brevior and longor were transplanted through the sheath of the long abductor of the thumb to give abduction to the thumb since their muscle bollies had pink enlared faseleuli.

The forcarm was derotated to 20 degrees of pronation on November 25–1946 into a position of function for the shoulder to be arthrodesed. This shoulber operation was performed on December 2, 1946.

When he was last seen in June 1947 the wrist and aboutder were well fused. The thumb was hold in abutetion in the plane of the hand and could be drawn in a little by weak thenar muscle power. He could hold a package of cigarettes between thumb and index finger (Fig. 6)

In the hand of Erbs palsy a different kinetic attaction is seen, especially when the disability is associated with the not infrequently seen par

alytic supination contracture of this malady.
The forearm is supinated. The wrist is doral flexed and ulnarly adducted by gravity and by paralysis of the wrist flexors. The thumb is in drawn. The elbow is flexed, the shoulder in ternally rotated and somotimes alklueted. The contracture is due to the selective paralysis of the muscles arising from the internal epicondyle of the humerus. This study of supination contracture will be reported later in detail.

The wrist is ulnerly adducted by an extensor carpi ulner is muscle whose strength is below normal since it too is affected by the palsy. There is no power in the flexor carpi ulners. The long abductor of the thumb is paralyzed.

The extensor longus policis is sometimes paralyzed and the distal joint of the thumb is flexed if the flexor longus policis has power

There is a significant difference in the behavior of the thumb in infantile paralysis and in Erb s palsy, which is abduction in the former and opposition in the latter

The problem here is the restoration of kinetic balance of the thumb. In Ech's palsy it means the restoration of abduction, using the extensor carp ulnaris muscle as the transplant. The operation is not a primary operation for it is usually combined with wrist fusion, and some-

Rotation of

times with osteotomy of the radius. It is the analogue of the triple arthrodesis of the foot with transplantation of the peroneus longus through the sheath of the tibialis anticus.

Before I devised this transplantation, the attempt had been made to solve this problem by suturing the paralytic tendon of the abductor longus policis to the active tendon of the extensor carpi radialis longior, somewhat as Hoffa did it ³

Case 7—This operation was performed on February 26, 1943, on a boy of eight with a left Erb's palsy. The hand was diffusely weak. The thenar muscles had fair bulk, but he could not oppose beyond the middle finger because of adduction contracture of the thumb, weakness of the long abduc-

the forearm was fairly strong and not restricted

The patient was seen last on November 8, 1945, when he did show fair power of the long abductor muscle but he could not yet oppose beyond the middle finger. The thumb could not be spread as much as the normal right thumb by mild adduction con-

tor, and weakness of the opponens

tracture The thumb tended to be dorsally placed
The patients in whom the extensor carpi
ulnaris was transplanted all had supination
contracture of the forearm

Case 8—Natable D, twenty-two years old, had a right Erb's palsy (Fig 7) At the age of four the



Fig 7 Preoperative photograph (February 2, 1945) to show the supination contracture of the fore-

right upper extremity of the patient was manipulated and immobilized in plaster, the shoulder being abducted 150 degrees and externally rotated, the elbow extended, and the forearm supinated. The airplane position is bad for any patient with supination contracture of the forearm or pronator weak-

ness The forearm should be held pronated
In July, 1940, when she was seventeen years old,
a wrist fusion and transplantation of the flevor earpi
ulnaris to the common extensors of the fingers was
performed by another surgeon

Osteotomy of the radius which pronated the forcarm and the extensor carpi ulnaris transplant were carried out on March 26, 1945. At the same time the elbow was manipulated into extension and the fingers flexed at the metacarpophalangeal joints to

The result is good (Fig. 8) She was seen peri-

odically until November, 1946 She can hold ob-

overcome their contracture in extension

pects in the right hand and can use it for knitting and sewing. The thumb can be abducted actively (Fig 9a and 9b). The forearm is held in the neutral position, for the transplant may also act as a supmator. The radius is bowed ulnarly.

Case 9—This patient, Naomi H, a fifteen-year-

old girl, had Erb's palsy (Fig. 10)

Osteotomy of the radius to correct supmation contracture of the forearm was performed on March 1, 1943. This osteotomy was revised on November 15, 1942, heavy and the contraction of the contraction when the contraction of t



Fig 8 Postoperative photograph (October 4, 1945) The forearm is now pronated but the radius to box ed ulnurly (Casa 8)



Fig. 9a. Photograph (October 9, 1946) showing active abduction of the thumb

fusion and the extensor carpi ulnaris transplantation were done on July 10, 1045

The patient has been followed for sixteen months and is quite pleased with the result of the operation. She can hold a small object between thumb and fingers, and can bring the thumb out of the palm by action of the transplant and the extensor longus pollucis (Fig. 11)

Case 10 - Harriet E was a girl of fifteen with left Erb's palsy

The left wrist was fused on July 28 1937 at the age of six, a common error in the treatment of suplnation contracture of the forearm

Osteotomy of the radius at its midpoint on March 6, 1944 and supracondy lar osteotomy of the hu



Fig 9b The patient holds a fountain pen in a natural manner



Fro 10 Preoperative view (July 4 1945) showing indrawing of the thumb (Case 9)

merus on March 20 1944 were then performed. On August 9 1944 esteolomy of the radius and ulna was carried out because of marked ulnar bowing of the radius and ulna.

Combined revision of the wrist fusion and extensor carpi ulnaris transplantation was done in July 1945. It was not possible to bring the tendion end to the base of the first metacarpal bone because an Esmarch bandage had been placed about the fleshypart of the short forearm. The tendion of the ex-

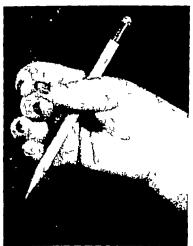


Fig 11 Postoperative view (March 16 1940) The thumb can be withdrawn from the palm and hold an object (Case 0)

tensor carpi ulnaris was attached to the tendon of the long abductor by several interrupted silk sutures, the adjacent sides of the two tendons being scarified

There was a subsequent admission for removal of a sequestrum on March 25, 1946 This sequestrum was derived from the partly necrotic cortical tibial graft, an occasional complication after this form (Albee) of wrist fusion

The appearance of the extremity two years after tendon transplantation is good. The patient stated that function of the hand had not greatly improved. She was able to hold several sheets of paper between the thumb and fingers. The thumb was kept out of the palm, and she could bring it to the radial side of the index finger, flexing the fingers at the same time. She could carry the thumb back with very slight transplant action being felt. The metacarpophalangeal joint of the thumb moved at the same time.

Case 11—This patient was a girl, twelve and a half years old, with a right Erb's palsy—Osteoclasis of the right forearm was performed on August 24, 1942, to correct the supination contracture after the method of Blount 7

Stripping of the collateral ligaments of the metacarpophalangeal joints to correct their extension contracture (Shaw operation) was done on August 23, 1943, after manipulation of these joints had failed

On November 12, 1945, osteotomy of the radius was performed to correct recurrent supmation contracture At the same time, an extensor carpi ulnaris transplantation was performed, the tendon being attached to the extensor pollicis longus tendon at the level of the wrist The reasons for this operation were, first, that the long abductor of the thumb had some power and, second, that the distal joint of the thumb was held fleved, because its long extensor The tendon of the extensor carpi was paralyzed ulnaris was passed through the sheath of the extensor longus pollicis, and the two tendons were sutured side by side at the level of the wrist

The results were good The period of follow-up

was one and a half years She can extend the tip of the thumb actively, but the thumb is held in the flat hand position by combined action of the long abductor tendon and the transplant The patient can hold objects between the thumb and fingers Opposition is possible to the middle finger

The arthritic hand and the hand disabled by injury rarely offer the problem of substitution indicated by this study. The extensor carpiulnaris may be used to replace a torn long abductor or long extensor of the thumb, as in the delayed frictional tears of these tendons after fracture of the radius.

Conclus on

The operative procedures for balancing the thumb are now made more complete by the addition of this tendon transplantation

The result of this operation is satisfactory. Our standard is relative and not absolute, since the transplant is usually weaker than normal. The result is good in the positive sense if the transplanted tendon is strong enough to keep the thumb out of the palm. In the negative sense, it is a tenodesing operation

The operation is a useful one and should become one of the standard tendon transfers

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NEURO ALLERGY IN CHILDHOOD

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URING the past thirty-odd years since the first recognition of the relation of personal khosyncrasies to certain diseases and the birth of the science of allergy, the appreciation of the importance of the allergic diseases has steadily grown among the pediatrists internists and otolaryngologists Today, the pediatrist not equipped to make an allergie study, is timorous about treating a case of asthma hay fever hives. or erzema Some are now beginning to be aware that a large percentage of the children with snuffly colds, recurring bronchitis or intestinal cohe are as much allergic patients as are those with typical asthma. More and more pediatrists are including skin testing and the other procedures of the allergist's armamentarium in the course of their regular practice or are referring patients to the specialist in the allergic diseases

There is, however one group of allergic mani festations which is still not thoroughly appreci ated except by those who are devoting their attention largely or exclusively to the study of allergy This is the group showing symptoms caused by allergic reactions occurring in the cranial cavity involving cither the meninges or

the brain tussue

The three characteristic results of an allergic reaction are amouth muscle spasm, local edema and increased glandular secretion. If as a result of an allergic reaction muscular spasm occurs in the arteries of the brain, definite neurologic symptoms may be expected to follow Localized cerebral anemia may cause transient paralysis dizziness and many other symptoms familiar to the neurologist. Similarly sudden edema of the bram or meninges or increased secretion of cerebrospinal fluid can cause increased intracranial pressure and symptoms simulating meningitis or brain tumor A minnt urticana of the brain or meninges would produce symptoms strongly resembling cerebral tumor

The characteristic symptoms of increased intra cranial pressure are headache vomiting, disziness increasing blindness, paralysis and paresthesia convulsions, and psychotic changes in the mentality Each and every one of these has been seen in association with other manifestations of an allergic condition or has appeared alone as a manifestation of an allergic reaction in the cen tral nervous system

In the year 1927, the late Victor Vaughan

proved conclusively that one of the most com mon causes of migraine headaches was the ingestion of food against which the nationt had an allergic idiosynemsy, an observation confirmed by many others and now universally accepted by all aller ists and acknowledged by many neurologists 1 A feel years ago Goltman reported a case where a decompression operation was per formed on a young woman, suffering from migrame headaches in the belief that she had a brain tumor 2 A large flap of skull was removed and not replaced The patient continued to have the migraine attacks and whenever these occurred, the skin over the skull opening bulged so markedly that it could be seen from a distance of reveral feet When the bulging subsided the symptoms disappeared, and the opening remained depressed until the onset of the next mi graine attack.

There can be little doubt that many children who have nek headaches are really sufferers from cerebral allergy both headaches and vomiting being the direct result of increased intracranial pressure due to allergic edema of the brain Several authors too, have urged serious considera tion of the possibility that cyclic vomiting, that bugbear of the pediatrist, is also a manifestation of allergic intracramal edema. This is a theory well worthy of serious study

If the intracranial edema occurs in the neigh borhood of the optic nerve the resulting pressure may cause temporary reduction of vision or actual blindness with retinal swelling and choked disk the symptoms clearing rapidly with the withdrawal of the allergic reaction. If the local edema occurs in the region of the auditory nerve or the semicircular canals, the symptom complex known as Méniero a syndromo consisting of ring ing in the cars, deafners and dismness sometimes so marked that the patient falls to the ground. may occur These manifestations of intracranial pressure due to an allergic reaction are well recognized as occurring in adults. They should be kept in mind when similar unexplainable bisarre neurologic symptoms are seen in child hood

That severe attacks of pempheral neuritis. causing excruciating pain and local paralysis may occur as a result of cerebral or spinal cord edema produced by allergy has been proved by Foster Kennedy and confirmed by many writers 3 The most typical form of this is that resulting from serum sickness. This distressing complication has usually followed injection of tetanus

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antitovin but may be produced by any of the sera used for prophylaxis or treatment

The symptoms usually appear within twelve to twenty-four hours after the appearance of the urticaria of the seium sickness For some unknown reason it almost always involves the distribution of the fifth and sixth cervical nerves At first there is pain in the shoulders, so excruciating that it is not relieved even by large doses of This may last for several weeks After one or two days a weakness of the arm appears, followed by rapidly developing atrophy of the deltoid and at times of other muscles of the shoulder girdle, especially the supraspinatus and infraspinatus muscles The paralysis usually remains fairly complete for about three months, after which power gradually returns to the arm, the atrophy slowly disappears, and from six months to a year after the attack complete restoration of function of the arm has taken place In a small percentage of the cases, however. recovery is not complete and a partial paralysis remains permanently

Care should be taken to warn all patients to whom tetanus serum has been given that if they have pain in the shoulders to return at once Early treatment with epinephrine and intravenous injections of hypertonic sucrose or dextrose solutions are believed to reduce the edema at the nerve roots and to lessen the nerve damage

Kennedy and other authors have reported incidents of allergic cases, sometimes associated with asthma, migraine, or urticaria, and sometimes alone, with recurring attacks of local anesthesia or paresthesia of the hands followed by temporary paralysis, in which the symptoms disappeared promptly on the administration of adrenalin and could be prevented by eliminating from the diet the foods to which the patient was sensitive 4

The cause of infantile convulsions, unassociated with injury or disease of the central nervous system or with fever, has long been a puzzle to Teething, indisgestion, the medical profession overfeeding, and worms have been cited as the underlying factors This subject has been only touched upon in the literature on allergy, and no systematic allergic study has been made, although as far back as 1921, Thompson in London in a study of 200 cases of infantile convulsions stated that they were usually due to poisoning from milk, cereals, or eggs, the foods which are the most common factors in the production of allergic shock.5 In this report Thompson said "There can be little doubt that the interesting, and as yet only partially understood, process of anaphylaxis plays an essential part in the causation of some, and perhaps many, morbid phenomena" He believed that continuing the offending diet in children prone to infantile convulsions might lead to asthma, eczema, and possibly epilepsy in later life. From my own observations I am convinced that at least a certain number of cases of infantile convulsions are due to allergic reactions in the central nervous system.

Case 1—A number of years ago a child, twentythree months of age, was brought to me with a history of convulsions occurring several times a day for two months Physical examination failed to explain the convulsions Intestinal parasites were ruled out by stool examination and anthelminties Skin tests, however, gave positive reactions to apple, date, beef, celery, spinach, dog hair, feathers, flaxseed, and cotton During the two weeks in the hospital, while the tests were being made, the child had from 3 to 10 convulsions a day On the basis of the completed tests, cotton and feathers were removed from the environment and the offending proteins eliminated from the diet The convulsions ceased The child remained free from convulsions during the next ten days of observation in the hospital and has had no recurrence since that time

The few allergists who have mentioned infantile convulsions in their writings have been very conservative in expressing any opinion on the subject, although some have stated the belief that if more attention were paid to the possibility of infantile convulsions being of allergic origin, a certain number of individuals who had convulsions in childhood might be protected against epilepsy in later life. Where there is a family or personal history of allergy, the possibility of unexplainable convulsions in any child or infant being allergic in origin should be given careful consideration.

With the single exception of migraine, epilepsy has received more attention from allergists during the past score of years than any other manifestations of allergy of the central nervous system. While the disease has been known since the earliest days and has been studied by thousands of investigators, the medical profession knows little more about the cause of epilepsy than it did in the days of Hippocrates. The one feature, common to all writings on the subject, is that in cases of epilepsy careful attention must be paid to the diet. The instructions as to diet have varied with each writer.

It is just a quarter century ago that Francis Ward called attention to the close relationship between allergy and certain cases of epilepsy in reporting the case of a girl, who, as an infant, had vomited all cows' milk, had infantile convulsions and attacks of petit mal, and from the ages of eight to fifteen had had numerous attacks of typical epilepsy ⁸ When it was found by skin testing that she was sensitive to milk, cheese, beef, and veal, and these were removed from her diet, the attacks stopped immediately

Many authors have reported convulsions due to allergy, some in association with other allergic manifestations as asthma or urticaria, some occurring alone with no other evidence of allergy but responding promptly to dictary regulation based on an allergic study. In 1937 Ward in association with Harold A Patterson skintested 1,000 epileptics at the Now Jersey State Village for Epileptics and at Craig Colony at Sonyea Now York, and found that 48 per cent of them responded to some allergen while only 8 per cent of a control group of 100 per cent were positive.

Since then, allergists all over the world have reported single cases or small groups of epileptics in whom the causative factor has been found to be an allergic sensitivity. In recent years the interest of some eminent neurologists notably Foster kennedy and Irving Paridee of New York, has been aroused by the relationship between allergy and epilepsy as well as other neurologic affections ^{1,4,8,9}. Both are now enthusiastic advocates of allergic investigations, not only of cases of epilepsy but of any neurologic symptom complex, the cause of which is not evident

Case 8-My interest in allergy as a cause of epilepsy started in 1931 when a ten year-old girl was referred to me The patient had had grand mal attacks for four years occurring twice a week recently In obtaining the history it was brought out that the child was also asthmatic An allergic study revealed sensitivities to cottonseed cattle hair radishes and cheese. These foods were removed from her diet but since she lived on a diary farm and cattle hair could not be climinated from her environment weekly inoculations with cattle hair were instituted and kept up for eight months. As the doses were increased not only was the asthma relieved but the epileptic seizures became less and less The last attack occurred in November frequent She has been quite well since then

Case 3 -Shortly thereafter a garl of sixteen came to me. She had had an egg intolerance as an infant, frequent colds, mucous colitis and hay fever the age of ten she had had epileptic convulnons varying from once a month to once in three months. Her allergic study demonstrated sensitivity to the fall pollens, numerous foods orris root, pyrethrum and tobacco She was given pollen injections and a rigid diet based on the allergic findings The result was that her mucous colitis cleared up and the next summer she was free from hay fever During the next three years that she was under observation she had but one mild convulsion which occurred when she was on a long automobile trip and eating at restaurants where she was unable to adhere to her dict."

Since that day I have examined many cases of chilepsy, including all those at both the Utica and Marcy State Hospitals where 75 per cent showed some ovidence of allergic sensitivity Short-handedness in the hospitals prevented following up these findings

In my private practice many cases of epilepsy have shown some evidence of an allergic sensitivity. Where this has been marked and where the patients were young most satisfactory results have occured. If the reactions were inconclusive and the epilepsy had contined for many years little benefit was obtained from any thera poutte efforts. Two recent cases have shown favorable results.

Case 4 —One (P B) is a boy of ten who came to no two years ago. It was an early case. In showed marked reactions to the dust from his home numerous molds, cat and dog hair and tobacco. His environment was regulated and inoculations commenced. His last convulsion was n June 1945.

Case 5 — Another girl (E. M.) a farmer's daughter came to my office in December 1944 with a history of epileptic attacks occurring from two to five times a day for two years. She showed sensitivity to cattle dogs horses and numerous molds. She received inoculations of the offending allergens and although not cured, in spite of the inability to remove her from her allergenic surroundings her attacks have been reduced from two to five a day to one or two attacks a month

It is a matter of common experience that the astlimatic child although amenable normally becomes irritable and disagreeable in the extreme during an asthmatic seizure. This nervous excitability is usually considered to be the result of the discomfort of the attack aggravating the child or of pampering by over-solicitous parents This is for the most part, true, but numerous cases have been reported by Shannon and other allergists in which high-strung, nervous unruly and disagreeable children who showed none of the accepted manifestations of allergy, have been found to be hypersensitive to certain foods, most commonly wheat 11 When the offending protems were removed from the diet these chil dren's mental attitudes toward life have changed and in a few weeks the spoiled irritable child has become happy contented and friendly

Case 6 —One such case came under my observa control way years ago. A boy of thirteen surly disobedient and willful had been expelled from four schools as an incorrigible pupil. His parents were at their wits' end as to what to do for him. Hearing that I was interested in child psychology they brought him to me to see whether I could unravel his peculiar complex.

Since he was a sufferer from hay fever I did a complete allergy study on him and found him to be sensitive to several foods as well as to the fall pollens. The foods to which he reacted were removed from his diot. On his returning to school the family were astonished to learn that he got along well was happy in his scholastic work had joined the Boy

Scouts, and was getting on well with his fellow

After several weeks of treatment the parents discontinued the boy's visits and presumably gave up the treatment outlined. A year later, I learned from outside sources that the boy had again become incorrigible

Case 7—On October 14, 1945, a boy of fifteen years of age was referred to me by Dr Richard H Hutchings The boy's father suffers from hay fever His grandfather had asthma He had had eczema when an infant and, since then, frequent attacks of For the past three years he urticaria and asthma had had attacks resembling petit mal During the same periods he had had frequent violent temper attacks, appearing with or without provocation, in which he smashed dishes or anything else on which he could lay his hands Excessive amounts of homework were sure to produce such an attack attacks lasted about a half hour Then he quieted down and was remorseful about what he had done He remembered all the details of the attack. During the five weeks previous to his first visit to me he had had five such attacks

On the first day of testing he gave 4 plus reactions to oats and wheat These were removed from his Since then, he has had no outbreaks Whereas on his first visit he was sullen and uncooperative, he now seems happy and desirous of going through with the testing He is meticulous about coming for his weekly injection although he has to hurry through his paper route and then travel 10 miles to reach my office in time For the past year he has carried on heavy schoolwork and, during the summer of 1946, made a trip of 30 miles daily to attend summer school During the whole year and a half under observation he had has no outbreak of any kind His entire attitude toward life has changed

Case 8—Two years ago, Wilmot F Schneider, in discussing the hyperkinetic child, reported a case of a girl of ten years who was so overactive and unmanageable that, although she had an IQ of 139, she could not be handled at home and had to be sent to a special school and was admitted finally to a hospital ¹² Here, an allergy study was made, sensitivity to orris root, pollens, and dust were discovered, and treatment was commenced Within three months the uncontrollable problem child had quieted down and become so amenable "that the mother and father were unable to believe that this was the same girl"

No allergist suggests that all cases of headache, paralysis, convulsions, or psychic maladjustments are of allergic origin. We do, however, believe that some of them are, and that in every such case where the causative factor is obscure, the question of there being an allergic background should be given serious consideration. Our little patients deserve that much from us

7 COTPAGE PLACE

Discussion

Bret Ratner, M.D., New York City—I would emphasize one salient feature of Dr Clarke's thesis

and urge pediatricians to regard cerebral disturbances that are transitory in nature, and in which the causative factor is obscure, as perhaps allergic in character

Dr Clarke presents an excellent case for attributing these transitory cerebral manifestations to arteriolar spasms of the brain vessels and the concomitant edema. Perhaps, I can best emphasize the importance of his thesis and continue his discussion in concrete fashion by omitting from consideration migraine, histaminic cephalalgia, Ménière's syndrome, epilepsy, and infantile convulsions and by confining my remarks to a further analysis of the cerebrospinal effects occurring in serum sickness and serum allergy

The allergic manifestations, resulting from the parenteral injection of foreign serum, lend themselves to accurate appraisal. The time of entrance of the otherwise innocuous substance always can be ascertained, and the material is not too complicated for a study of the component substances, nor does it possess primary toxicity when properly prepared

Consideration of allergic encephalopathies from smallpox or rabies vaccines, drugs, and antibiotics are somewhat complicated because of the primary toxicity of drugs and antibiotics and the complexity of the viruses. One cannot be too certain whether the reaction is allergic or the result of such factors.

Having established the fact that neurologic allergic sequelae can follow from the entrance of an innocuous foreign serum into the body, this information may help us to appraise similar sequelae from the use of such substances as sulfonamides, penicillin, streptomycin, virus vaccines, and others

With growing knowledge, it is becoming evident that the brain, the meninges, the spinal roots, and the peripheral nerves may be the site of more or less severe allergic reactions. These sequelae, as a rule, subside, leaving few if any residua. Notwithstanding the many reports of such allergic episodes, they are relatively rare. If the frequent occurrence of headache, nausea, vomiting, and neuralgia in the usual and well-known type of serum disease constitute a syndrome of neurologic origin, then a mild form of allergy of the nervous system is frequent It is further possible that many of these neurologic complications have been entirely overlooked in other situations.

- I have differentiated three types of meningitis following serum injections—serum sickness meningitis, aseptic or serum meningitis, and allergic meningitis.
- (1) Serum sickness meningitis results from an extrathecal injection of serum and manifests itself during the course of ordinary generalized serum sickness and accelerated serum allergy. The spinal fluid shows a preponderance of lymphocytes
- (2) Aseptic or serum meningitis results from the primary contact of the meninges with the serum after intrathecal injection. It is nonallergic, and polymorphonuclear cells are predominant in the spinal fluid.
- (3) Allergic meningitis may be a sequence to intrathecal injection of serum in the case of an individual who has been sensitized by previous

expenence with the serum It also is characterized by a predominantly polymorphonuclear spinal fluid but coupled with this finding are the profound allergic reactions of the nervous system

I am of the opinion that the spinal fluid cytology may aid in differentiating meningeal reactions Thus, any reaction that is predominantly lymphonytic would connote an extrathecal pathology such as exists in those diseases producing serous meningitis eg the lymphocytic phase of tuberculous meningi tis polio-encephalitis the lymphocytosus found in paracyphilitic diseases of the central nervous system and chorismening its. On the other hand, when there is a predominantly polymorphonuclear cell increase in the spinal fluid. I believe it is evidence that some foreign substance either chemical bacterial viral or serous has gained direct entrance into the spinal

During the period of general wrum sickness headache, nausen, vomiting, and neuralgia frequently occur The findings of a moderate increase in lymphocytes and increased fluid pressure in the rerebrosman fluid during the early stage of serum sickness indicate that a definite neurologic disorder be responsible for the bendache nausea and vomit

Corroboration of the conc pt that extrathecally injected scrum will if it affects the meninges result in a lymphocytic response is found in the first reported case of optic neuritis by Mason patient received 500 cc of anti-pneumococcal serum and eleven days later developed marked general urticaria temperature 104 F Scrum sick ness persisted for two weeks, and, three days later the patient became drown, and very dull the ophthalmoscopic findings the ccrebrospinal fluid showed increased pressure globulin was present and there were 150 lymphocytes per emm

The introduction of a foreign protein into the theea may produce a primary nonallergic effect and at times it may be so seriou as to cause death in a few hours from medullary and ecrebral edema But this primary reaction of the meninges must not be confused with allergic meningitis. The latter h a true hypersensitive reaction of the meninges which occurs only after a latent period following the primary sensitizing injection.

The cerebral syndromes may be characterized by choked disks, meningeal irritation the kernig festamons as aphasia, alexia, hemianopsia, and bemplezia. The spinal fluid pressure is much increased The cellular reaction is slight Associated paralysis of the cranial nerves or a bulbar syndrome with or without tetraplegia may occur. These avadromes are cen broneural

Among the other related neural and cerebral complications which have been described an various forms of peripheral neuritis optic neuritis retinal edema, and iritia

Ocular involvement in scrim sickness has apparently been the subject of few reports but they are extremely convincing and should awaken inter-

Other reports of recurrent paralysis of the larvax and auditory nerve involvement are of equal interest in showing that the cerebral form of allergy may or may not be combined with involvement of the emuial nerves

The physiologic pathology of the cerebrospinal allergic manifestations is the result of a combination of sparmodic vascular disturbances with consequent edema of the brain and permeural edema, causing pressure symptoms. This evanescent pathol ogy accounts for the generally good prognosis in all of the neurologic sequelac

If one bears in mind the many phases of these hypersonsitive reactions herein presented, it should aid in the diagnosis and differentiation of cerebrospinal reactions which may ensue following the use of such diverse substances as sulfonamides, penicillin streptomycin, hapamine virus vaccines food and other allergens.

I am sure that Dr. Clarke's paper will arouse a great interest in these neurologic phases of clinical medicine. I would emphasize his thesis that we as pediatricians, should become cognizant of the notential role that allergy plays in this neurologic symptomatology

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EFFECT OF SALAD DRESSINGS ON VITAMIN C

Salads made with French dressing were found to retain more of the vitamin C of the greens than aimilar salads made with the same amount of plain vinepar (acetic acid) The explanation for this observa tion may he in the fact that vinegar apparently contains traces of metals which haston the oxidative destruction of vitamin C Seasonings in the French dressing however were thought to exert a protective action on the vitamin.

The losses in vitamin C became apparent after a

period of two hours during which the salads mixed with dressing were kept standing in enameled bowls at room temperature. Following good culinary prac tice which dictates that greens be served well chilled and mixed with the dressing just before eating therefore insures not only palatable salads but maximum retuntion of their vitamin content—Borden s Review of Autrition Research January 1948

DIAGNOSTIC EXPERIENCE WITH HEPATIC SPECIMENS OBTAINED BY NEEDLE PUNCTURE

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(From the Edward J Meyer Memorial Hospital and the University of Buffalo Medical School)

O OBTAIN hepatic specimens we use a Vim-L Silverman needle which consists of a needle and a bipronged obturator with a cutting edge The site of the insertion varies from case to case, and we try to restrict biopsy to cases with clinically enlarged livers In a case with an extremely large, firm liver the approach is subcostal to the right of the rectus muscle When the liver is not greatly enlarged, the approach is through a lower intercostal space in the anterior axillary line well below the upper border of the liver, as determined by percussion If a mass or nodule is detected in the liver, such lesion is entered directly Bleeding, clotting, and prothrombin times should be carried out routinely before biopsy

The skin at the selected site of insertion is infiltrated with 1 to 2 per cent procaine to and including the parietal peritoneum. The skin is incised with a scalpel, and the Silverman needle introduced with the obturator point held withdrawn to a level even with the needle point. When the respiratory mobile liver is entered, paradoxical movement of the head of the needle occurs obturator is then passed deeper into the liver after which the needle is pushed in further with the obturator held in place. The motion thus produced forces the prongs of the oburator together and upon complete withdrawal of the obturator, a specimen of liver measuring from 18-25 cm in length and about 015 cm in diameter is obtained (Fig. 1) After fixation of the specimen in 10 per cent formaldehyde, paraffin sections, stained in hematoxylin-eosin, are made No clinical information is given the pathologist before he completes his report

Material and Results

From September, 1946, to March, 1947, we attempted to obtain hepatic specimens by needle puncture 46 times, 44 times from living patients and twice from 2 postmortem patients Fortyfour hepatic specimens proved to be satisfactory for histologic study One specimen was too small for conclusive interpretation, a second specimen was composed only of fibrous tissue A positive pathologic diagnosis could be made in hepatic

specimens from 33 patients In 9 patients, an indefinite or negative report for primary or significant disease of the liver had to be given positive diagnoses included fatty changecirrhosis 6, portal-Laënnec cirrhosis 14, portal cirrhosis-tuberculosis 1, portal cirrhosis with pigment 1, metastatic carcinoma 3, leukemia with hemosiderosis 1, amyloidosis 2, heptocellular degeneration and necrosis 3, and obstructive naundice 2

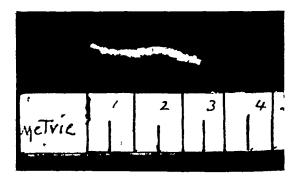


Fig Gross specimen obtained by needle puncture

Case Reports

Case 1 (Fatty change) -C F, a thirty-one-yearold man, had a history of heavy alcoholic ingestion for one year He was admitted to the hospital in acute intoxication Acne rosacea was present. The liver was palpable 3 fingers breadth below the costal Hepatic biopsy disclosed a fatty liver of moderate degree Laboratory work was as follows serum bilirubin 1 mg per 100 cc, prothrombin time was not increased, bromsulfalein test 26 per cent retention after one hour, hippuric acid 044 Gm, benzoic acid 03 Gm, cephalin flocculation test 1 plus, alkaline phosphatase 62 Bodansky umits, nonprotein nitrogen 36 mg, total protein 6 6 Gm, serum albumın 3 7 Gm, globulın 2 9 Gm

Case 2 (Fatty change-cirrhosis) —G B, a fifty-nineyear-old man, was admitted for acute alcoholism There was a history of emesis of dark material The skin and sclera showed icterus The liver was enlarged Hepatic biopsy showed fatty changes with portal cirrhosis Laboratory data recorded the folserum bilirubin 20 mg per 100 cc, prothrombin time with twenty-second control, sixteen seconds, bromsulfalem test 32 per cent retention in one hour, hippuric acid 0 67 Gm, benzoic acid 0 45 Gm, cephalin flocculation test 3 plus, formol gel

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test 4 plus, alkaline phosphatase 102 Bodansky unita nonprotein nitrogen 24.3 mg. total protein 69 Gm. serum albumin 2 Gm, globulin 40 Gm

Case 3 (Latince's curhous)—J S a fifty three-year-old man with a history of alcoholism had anorexa, hematemesis, and ascites. Learnination revealed slight jaundice enlarged liver prominent abdominal venus ascites and spider anglomas Hepatic biopsy indicated Latince's cirrhous. A report of laboratory data was as follows serum bilirubin 41 to 05 mg per 100 cc. prothrombin time eighteen seconds, control fifteen seconds bronsulfale in test 165 per cent retention after one hour hippure acid 0 148 Gm benzote acid 0 10 Gm, cephalin flocculation test 2-4 plus formol gel test 1 plus alkaline phosphatase 77 Bodansky units nonprotein nitrogen 25 mg. total protein 5 5 Gm, globulin 2.7 Cm.

Cose 4 (Metastatic carcinoma)—J M. a seventy two-year-old woman was brought to the hospital for weakness. She did not cooperate during the examination. The skin and mucous membranes were pale and slightly ieteric. The liver was smooth, palpable 2 fingers breadth below the costal margin A mass felt in the left upper part of the abdomen was thought to be spicen. Peripheral lymph nodes were enlarged. Hemoglobin 45 per cent red blood cells 8 500 000 per cu, mm. white blood cells 20 700-40 450 per cu, mm. with 95 per cent neutrophils Hepatic biopsy indicated adenocarcinoma, apparently metastatic. The autopsy findings were primary carcinoma of stomach with metastases to liver, lung, pleura lymph nodes adrenal gland and bone (Fig. 2).



Fig 2 Metastatic adenocarcinoma (Case 4)

Case 5 (Leukemia-kemoniderosis) — J Q a sixty infine-year-old man had swelling of the abdomen There was a history of alcoholism. On examination the tyleen and liver were palpable. Ascites was present. The white blood cell count was \$2 000–100 480 ler cu mn with 08 per cent lymphocytes. Hopatic blopsy showed leukemic (chronic lymphatic) infiltration in periportal zones with marked hemosiderosis Laboratory work was reported as follows serum bilirubin 1 mg. prothrombin tume not increased hippure acid 0 11 Gm benzole acid 0 08 Gm ceptahin flocculation test 2 plus formol gel test 3 plus total protein 47 Gm

Case 6 (imyloudous) —J P a thirty three-year old man, had had chronic pulmonary tuberculosis since 1940. The liver and spiece were palpable. The urine was negative for albumin. Hepatic biopsy indicated diffuse amyloidosis. Laboratory work was as follows—serum bilirubin 0.3 mg. por 100 cc., prothrombin time nineteen seconds control seventeen seconds, bromsulfalein test no retention after one hour hippuric acid 0.2 Gm—benson acid 0.14 Gm—cophalin flocculation test 1 plus formed gel test 4 plus alkaline phosphatase 7.3 Bodansky units—nonprotein nitrogen 25 mg total protein 6.2 Gm—serum albumin 3 Gm. globu lin 3.2 Gm.

Case 7 (Hepatocellular degeneration)—P M a forty-soven-year-old man had jaundies for one month The liver was enlarged and tender At operation no extrahepatic obstruction was found. Surgical blopsy revealed marked hepatocellular degeneration. In hepatic biopsy obtained by needle puncture five weeks later only slight regressive changes of the type noted in the surgical specimen remained. Laboratory data recorded the following sorum bilimbin 33 2 23 8, 17 2, 11 4 6 1 mg., hippuric acid 0 34 Gm bic noice acid 0 2 Gm, cephalin foeculation test 0 formol gel test 1 plus alkaline phosphatase 6.5 Bodansky units nonprotein nitrogen 21 6 mg total protein 5-6 Gm albumin 37 Gm

Case 8 (Obstructive jaundice) -G B arixty yearold man, complained of saundice with chills and fever. He had suffered a similar attack one year Leukocytosis was present. The liver was nainable 2 fingers breadth below the costal margin Hepatic biopsy revealed obstructive jaundice, ascending cholangitis and pericholangitis early abseess. At operation the gallbladder and common bile duct contained numerous black calculous gran ules 2-3 mm in diameter. Other operative findings included cholcoystitis, cholangetis, and acute pancreatitis. Cholangiogram before discharge of pa tient revealed patency of the common bile duct. The report of the laboratory data was as follows scrum bilirubin 13.0 to 1 mg per 100 cc prothrom bin time twenty seconds control sixteen records cephalin flocculation test 1 plus formol gel test 1 alkaline phosphatase 66 Bodansky units nonprotein nitrogen 27 mg per 100 cc total protein 05 Gm serum albumin 3.8 Gm. globulin 2.7 Gm.

Case 9 (Negative report for primary kepatic discase) - E. H. a fifty-seven-year-old man complained of swelling of the abdomen, anorexia weight loss and abdominal pain. The liver was palpable 6 fingers breadth below costal margin. The spleen was questionably palpable. Recurring ascites was present The clinical impression was Laennees cirrhosis. Two hepatic biopsies, however, disclosed no curhosia. Lobular structure was preserved Congestion with regressive changes in central veins was noted. On the basis of the hepatic biopsies the chnician a attention was directed toward the possibility of metastatic carcinoma or Chiari s syndrome. Laboratory data indicated the following serum bilirubin 0.3 mg, per 100 ec. prothrombin time not increased, bromsulfalein test 23 per cent retention after one hour, hippuric acid 0.24 Gm, benzoic acid 0.095 Gm, cephalin flocculation test 4 plus, formol gel test 4 plus, alkaline phosphatase 5.6 Bodansky units, urea N 18 mg, total protein 5.7 Gm, serum albumin 3.1 Gm, globulin 2.6 Gm

Operative and Postmortem Correlation — Microscopic examination of hepatic tissue obtained at operation in 2 patients, and at autopsy in 4 patients, confirmed the diagnosis made from the hepatic specimen obtained by needle puncture Needle biopsies repeated in 3 patients duplicated the findings in the original specimens

Clinical Aid—In 33 patients with a positive pathologic report and in 7 patients with a negative report for primary or significant discase of the liver in the specimen obtained by needle puncture. the clinician felt that he had received diagnostic In 2 patients histologic study of the hepatic biopsy yielded an indefinite microscopic interpretation of no clinical aid The patients in whom hepatic specimens obtained by needle puncture furnished aid to the clinician fell into 8 groups on the basis of the presenting clinical problem patients with enlargement of the liver for which a cause had to be established, (2) patients in whom it was important to exclude primary or significant hepatic disease, (3) patients with jaundice the type of which was sought, (4) patients with Laënnec's cirrhosis in whom it was desired to confirm the clinical impression, (5) patients with Laënnec's curhosis in whom the coexistence of primary carcinoma of the liver had to be checked, (6) patients from whom a tissue diagnosis of the liver was desired before undertaking certain types of therapy, (7) patients in whom it was deemed valuable to follow the course of hepatic disease by tissue examination, (8) postmortem patients in whom complete autopsy to check clinical diagnosis could not be done

Hazards and Limitations —In our series of 44 living patients we encountered no really serious

complication from needle puncture patient, however, at laparotomy subsequent to hepatic biopsy, a moderate subphrenic hemorrhage was found, a drop in the red blood count had appeared after the needle puncture patient where the hepatic biopsy showed purulent cholangitis and abscess, the question of infection of the peritoneal cavity was raised, at subsequent operation, no untoward effect was noted, the site of needle puncture could not be seen sides the risks of hemorrhage and infection, other possible hazards of needle puncture (not encountered by us) consist of perforation of the intestine or gallbladder, and injury to the kidney, adrenal gland, or pancreas Restricting needle puncture to patients with enlarged livers and with normal bleeding, clotting, and prothrombin times ought to keep the various hazards at a minimum

In our series the size of the hepatic specimen obtained by needle puncture was inadequate for conclusive microscopic interpretation on pne It must be remembered that any occasion pathologic interpretation is limited by the small size of even the largest specimen Furthermore, the findings in the needle biopsy may not necessarrly represent those in other parts of the liver The effects of crushing in specimens, although bothersome to a degree in our series, were not substantial or frequent enough to offer regular difficulty to the pathologist in his examination The hepatocellular picture in certain needle biopsies, immediately fixed, differs, apparently on the basis of glycogen content of cells, from that in routine postmortem sections We feel, on speculative grounds rather than from actual experience in our series, that constant success should not be expected from the needle biopsy in distinguishing extrahepatic obstructive jaundice from intrahepatic jaundice

INSANITY RATE HIGHER IN WAR YEARS

The US Census Bureau reported that there was an increase in insanity among Americans during the war years, 1940 through 1945, especially among men in the military age bracket. The question was posed whether the "psychologic hazards of military life" drove more men insane or whether the intensive psychiatric scrutiny given men in this age group detected more cases of insanity. The increase in insanity among women paralleled that of men, but it was less in the 20 through 34 age group

The report covered the rise in the rate of first admissions of psychotic persons and it ignored hos-

pital admissions of psychoneurotics and marginal disorders such as alcoholism, mental deficiency, or drug addiction. The estimated number of first admissions to hospitals for permanent care of all patients with psychosis increased from 71.7 in each nundred thousand of population in 1940 to 86.8 in 1945, an increase of about 21 per cent. The number of men admitted to hospitals as psychotics was 78.8 per hundred thousand in 1940 as against 96.4 in 1945.

Admissions more than doubled among men aged 20 to 24, rose 78 per cent among those aged 25 to 29 and rose 36 per cent among those aged 30 to 34

This study was aided by a grant from the Women's Auxiliary of the Edward J. Meyer Memorial Hospital

CARCINOMA OF THE OVARY ARISING IN AN ENDOMETRIAL CYST

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(From the St. Francis Hospital)

In gynecologic pathology there has hardly ever been a more controversial subject than the condition best known as 'endometriosis' Voluminous literature on this subject has appeared since the first report by Russell in 1899. In fact a whole monograph dealing with endometrous lass recently been published.

Endometrious presents two interesting fea tures first, the variety of clinical manifestations due to the wide distribution of the lesions second the problem of its pathogenesis. In regard to the latter a number of theories have been advanced, most prominent among which are the origin of endometrious from coelomic epithelium and Sampson's theory of "spill-over" of endometrial tirsue through the tubes into the abdominal cavity

Recently, we had an opportunity to observe the following unusual case of an ovarian endometrial cyst, showing areas of carcinomatous transformation

Case Report

The patient was a forty five-year-old woman who consulted one of us (A. L. R.) because of fullness in the abdomen and attacks of nausea during the preceding two months. The patient also stated that she had not menstrusted during that period to that time she had had a normal menstrual history of a twenty-eight-day type. She was married and had borne 3 children all of whom were alive and well. There was no history of abortion miscarriage or serious illness including operation She appeared to be well-nourished and in good health. However there was a mass extending from the pelvis up to the level of the umbilious, located somewhat to the right side oval-shaped not particularly tender fairly movable, and quite firm Vaginal examination revealed old lacerations of the cervix and on bimanual palpation the mass could again be felt to arise from the polvic cavity Both lower extremities showed marked varicosities. The urine and blood count analyses were essentially normal. The Wasser mann test was negative. The provisional diagnosis was pelvic tumor either ovarian cyst or uterine fibrold

A laparotomy was performed on November 7 1945 Through a lower midline meision the abdomen was explored. The uterus could not be seen at first, because it was conecaled by a huge right ovarian mass, adhering to it in various areas. The mass was also adherent to other structures of the cul-do-sac, including the rectum for a distance of 7 to 8 cm. In some places the mass was adherent to portions of the transverse colon and small intestine. The left ovary was enlarged and cystic. It too was adherent to the utrus to the left lateral abdominal wall, and to the broad ligament

The right ovarian mass was freed but it ruptured as it was about to be excised allowing thick chocolate-colored fluid to escape into the abdominal cavity. The resection of the mass was nevertheless completed. Its adhesions to the rectum were very dense and it was necessary to 'denude the rectum for a considerable distance in order to free them. The left adness and the supracervical portion of the uterus were removed together. Following the operation the patient made an uneventful recovery and was discharged after three weeks.

The uterus and adneta were received for examina tion The uterus measuring 8 by 6 by 5 cm., had been amputated across the lower portion of the cervical canal. The endometrial cavity measured 6 cm. in length and in its fundal portion there was a pea-aised mucosal polyp The myometrium contained a grayish white nodule which measured 1 cm. in diameter The left tube measured 5 cm. in length 1ts fimbriated end was patent. The left ovary measured 0 cm. in the longest diameter and contained 3 cysts 2 of which were filled with clear straw-colored fluid, while the third one presented some reddish brown viscid fluid.

The right overy was transformed into a large eystic mass which measured 16 cm in the longest diameter When it was received in the laboratory it was partly opened and collapsed. The external surface of the cystic mass presented many fibrous adhesions. The cyst wall varying in thickness was quite thin in many areas, while in others it measured up to 1 cm. in thickness. The cyst contained much thick, chocolate-colored fluid. The inner lining of the cyst was gray in some places, and a dark brown, chocolate-like color in others. In a few scattered areas the inside of the cyst presented yellowish-pink to yellowish-gray friable papillary excrescences which did not exceed 3 cm. in width and 1 cm. in height Detached pieces of apparently identical tissue were found floating in the chocolate-colored fluid filling the cyst The right tube measured 7 cm. in length. Its fimbriated end was patent.

Microscopic examination of the uterus indicated that the endometrium was in proliferative phase. In some areas the glands some of which were dilated, seemed to be more concentrated in number and dipped into the myometrium. The nucesal polyp contained endometrial glands such as seen in the proliferative phase and here too some glands were dilated. The nodule in the myometrium was found

Presented at the 141st Annual Meeting of the Meetlers Sociaty of New York State, Buffalo Section on Pathology and Clindes! Pathology May 7 1917 Since this article was submitted for publication another the pathology of the Present States in an endometrial

care of eardioms of the overy arising in an endometrial crat of cardinoms of the overy arising in an endometrial crat has been reported by Dr. Emil howsk in the Jeursal of the Meunt 5 and Herpital 14:529 (1947)



Fig. 5 Area of infiltrating squamous cell carcinoma

The study of this problem, both from the clinical and diagnostic point of view, gained fresh impetus through the extensive investigations of J A Sampson 5-9 His theory, now well known and rather widely accepted, maintained that during menstruation viable fragments of endometrial tissue as well as tubal mucosa may be "spilled over" by retrograde motion into the peritoneal cavity Here, these fragments may become implanted on the ovary, which is next to the fimbriated ends of the tubes and therefore most frequently involved, and on other structures of the peritoneal cavity Once such endometrial fragments have successfully engrafted themselves on other organs, they may become transformed into cysts, whose lining epithelium in response to hormonal stimulation may participate in the hemorrhages associated with the menstrual cycle Spontaneous perforation of such cysts could occur at an early or late date and give rise to the formation of secondary endometrial cysts in the same The occurrence of adhesions is or other organs another complication of spontaneous perforation of endometrial cysts

The presence of decidual reaction in some endometrial cysts was cited by Sampson as another proof for his theory. However, decidual reaction outside of the pelvic organs has been

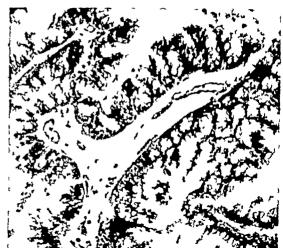


Fig. 6 Area of mucous cell carcinoma

observed without endometriosis during pregnancy. The recent report of ectopic decidua in the subserosa of the appendix vermiformis by Sanes and Liber would not support Sampson's conclusions ¹⁰. In regard to adenomyosis of the uterus itself, Sampson suggested two possibilities, namely, invasion of the endometrial cavity and extension from perimetrial implants ⁵. He also



Fig 7 Adeno-acanthoma

expressed the belief that, occasionally, the implan tation of normal endometrial tasue in the ovary may lead to the development of ovarian carcinomas In his numerous papers, Sampson presented a great number of case reports to support his theory, thus contributing materially to the clinical knowledge of this subject. Indeed, such rare lesions as endometrial implants in laparotomy scars, following operations in which the uterine cavity has been opened, are now well known, there seems to be no question that in these cases, at least, transplantation of endometrial tissue led to endometricsis

The opinions expressed by Sampson in his were not uncontested Robert Meyer came out very strongly in favor of the peritoneal epithelium being capable of giving rise to endometrum-like structures and stated in addition, that inflammation was probably an important factor in the development of endometnoss.11 Furthermore, he pointed out, as Lauche, Pick and others had done earlier the close rela tionship between the peritoneal epithelium and Muellerian duct structures Indeed, in the classic Manual of Human Embryology, by Keibel Everything and Mall, we find the statement that is later developed within the genital fold has a common origin from the coelomic epithelium," and a recent textbook of embryology states Muellerian ducts seem to arise independ

ently by a process of infolding and then closing off of a groove in the coelomic mesothelium paral

lel to the mesonephric duct. 12 13

Tobler described the occurrence of endometrium-like proliferations on the sigmoid colon.14 He, too, accepted the peritoneum as the source of these proliferations. Emil Novak, in a detailed analysis of this problem, discussed first the embryologic angle pointing out that the genital tract and germinative epithelium are derivatives of the coclomic epithelium and as such are actu ally only a modified perstoneum.15 Under hormonal influence this altered coelomic epithehum, which retains a remarkable sensitivity to ovarian hormone, develops in different directions, such as the glandular patterns of the fundus and the cervical canal, and the squamous cell lining of the cervix. In the further course of his discussion Novak emphasized the fact that the direc tion of the movements of the cilia in the tubes as well as the direction of the tubal peristals is pointed toward the uterus He also felt that the lumen of the isthmic portion of the tube is too narrow for the passage of endometrial material, and lastly, he was not convinced of the viability of the cast-off menatrual epithelium a point which he used to question the validity of Jacobson s experiments using normal endometrium for transplantation 14

About the same time, Halban presented still another theory, expressing the view that desquamating fragments of uterine mucosa may enter lymph vessels and subsequently reach ovaries, peritoneum, abdominal wall, and even the inguinal region 17 This theory however, did not find many supportors, and today, it may be con sidered entirely abandoned

Aschoff strongly endorsed the coelomic theory and suggested that all endometrics be referred to as "blastomatoid or blastomatous formations of the cloacal portion of the coclomic epithelium ' which may arise either in the course of early developmental anomalies, under endocrine ovar ian influence, or, finally as secondary results of inflammatory processes 18 Recently wald concluded, too, that the coelomic walls should be considered capable of giving rise to new endometrial formations. 19 29 He believes that both epithelial and connective tissue elements of the coelomic wall can participate in this creation of endometrial tissue and explains the occur rence of endometriesis in the uterine wall, not connected with the endometrial cavity and even in uterine extremities on this basis.

We believe that the findings in our case tend to support the coelomic theory of endometrious By far, the greatest portion of the right ovarian cyst presented characteristic features of a socalled endometrial cyst. Carcinomatous trans formation of such cysts has previously been postulated, and, recently, a case was described by McCullough, Froats, and Falk. 11 In addition, Kuzma reported two cases of ovarian adenoacanthoma associated with endometricus of the overy and suggested the possible transformation

of the latter into carcinoma. 22

In our case the predominant appearance of the malignant portions was adenocarcinomatous. such as is found in fundus carcinomas of the uterus In addition, there were also squamous cell and mucous cell carcinoma elements, thus repeating the potentialities of the entire Muel lerian duot Surely, the presence of these three cellular elements points rather toward origin in the germinal epithelial calls lining the ovarian surface than toward origin in the fully differentiated uterms endometrial cells. It is a well known fact that surface epithelium of the overy may dip into the parenchyma, thereby producing tubular and gland-like structures surface epithelium itself is flat or low cuboldal, its deeper invaginated portions display a tendency toward columnar cell formation, frequently associated with a condensation and special arrangement of the underlying stroma, lending an appearance very similar to that of endometrium We are inclined to believe that this is the mech anism for the development of most 'endometrial'

In our case the endometrial cyst developed further to the ultimate extreme, namely, carcinoma, embodying several cellular elements which the multipotential coelomic epithelium is capable of producing We also suspect that the presence of endometriosis in the wall of the right tube, and, in addition, the presence of adenomyoma in the myometrium, are perhaps the expressions of an increased endocrine stimulation. responsible for the initiation and further development of all the changes described in our case

Summary

- A case of endometrial cyst with areas of carcinomatous transformation is presented
- Representative portions of the literature were discussed in regard to the different views on the subject of endometriosis
- The case presented in this paper appears to support the coelomic theory of endometriosis

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ESTROGEN AND UTERINE CANCER

To the Editor —There is admittedly difference of opinion and conflicting clinical and experimental evidence as to the possible role of estrogenic hormones in the production of uterine cancer can be no difference of opinion, however, as to the harmful effects of estrogens when their ill-advised use delays the diagnosis of uterine cancer and permits an early curable lesion to advance to a stage at which cure is no longer possible

Bleeding is usually the first sign of uterine cancer, and it is perhaps not surprising that the patient, particularly at the time of her menopause, often confuses pathologic bleeding with functional disturbances of menstruation It is indeed a tragedy when her physician also confuses bleeding with abnormal menstruation and embarks on a program of estrogen therapy without first making certain that he is not

dealing with uterine cancer To realize that such a diagnostic error is by no means a rarity, one has only to review the histories of even a moderate number of patients suffering from an advanced stage of uterine

A constant stream of colorful pamphlets advertising estrogens pours from the mail onto the desk of every physician How seldom they contain a word of caution that the patient's symptoms may be due to cancer

One might wish that on every ampule and on every package of tablets containing estrogens there

could be printed in red letters
"DOCTOR, ARE YOU SURE YOUR PATIENT
DOES NOT HAVE CANCER?"

C J Attwood, M D, Samuel Merritt Hospital, Oakland, California—J A M A, January 10, 1948

DIFFERENTIAL DIAGNOSIS OF CONGENITAL HEART DISEASE

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'ONGENITAL heart disease can be cured by With this announcement various lay newspapers and magazines mothers with children, diagnosed as congenital cardiacs are rushing to physicians for the cure many years the child born with a defective heart was considered a medical curiosity and rarely was a differential diagnosis attempted recent advances in surgery of the chest and following the pioneer work by Gross and Blalock on congenital defects of the circulators system at has not only become important, but even imperative for the chnician and especially the pediatrician to make a definite diagnosis of the underlying car disc defect 12 Unfortunately of the ninety-odd types of concenital heart defects only three or four are amenable to surgery at present.

However of these many varieties 85 per cent can be divided for the purpose of simplification into 8 important entities. Eliminating the rare and complicated conditions and concentrating upon the more common 8 syndromes, makes it possible for the clinician to venture a correct opinion. It is interesting to note that approximately 15 per cent of children ill with heart disease, suffer from a congenital heart defect.

The purpose of this paper is to present a simplified plan for diagnosing the more common types of congenital cardiac defects. During the period of early infancy, the various congenital lessons have indefinite manifestations and very often present no gigns at all This makes a diagnosis at this age period not only uncertain but often impossible Frequently in early infancy cyanosis may be delayed for some months and even years in the presence of quite a high degree of raised oxygen unsaturation produced by direct admixture of venous blood with the arterial stream so that its absence in infants with physical signs indicating the presence of a defect, does not necessarily exclude a lesion of the cyanotic group This means that all blue babies need not be blue at birth or during the early months of

Cyanosis in congenital cardina defects is due to two factors (1) The admixture of venous blood in the arterial blood stream, and (2) deficient circulation in the pulmonary system Figure 1 presents a logical explanation for the delayed cyanosis in those infants who actually belong to the cyanotic group Striped portions

Presented at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo Section on Pediatrica May 9 1947 signify venous blood white portions (in this case only the umbilical veins) represent fully oxygen ated blood and the dotted portions, the admixture of venous and arterial blood. One can readily see that except for the head no oxygen reaches the infant, and so it is quite likely the fetus, which has adjusted itself to exist with very little oxygen during the nine months of prenatal life, may continue to do so during the neonatal period.

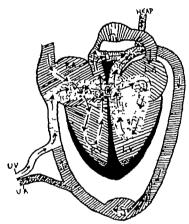


Fig. 1 Fetal circulation.

For the differential diagnosis of congenital heart lesions it is of first importance to place the case into one of two categories those without cyanosis (acyanotic), and those with cyanosis (cyanotic) Having properly grouped the patient, the next important consideration is the heart murnur with its point of maximum intensity time of cardiac cycle area of transmission, and quality

The most frequent defects, causing heart mur murs in the acymnotic group, are as follows

- a Patent interventricular septum (small)
- b Patent ductus arteriosus
- c. Aortic coarctation

d. Subaortic stenosis

Patent foramen ovale should be included in this group but because it rurely, if ever presents any signs or symptoms it may be ignored.

The most common defects, causing heart murmurs in the evanotic group, are as follows

- a Pulmonary stenosis (usually tetralogy of Fallot)
- b Large septal lesion (ventricular or auricular)
- c Eisenmenger complex
- d Transposition of the great vessels

In order to identify properly the members of these two groups, a résumé of the important characteristics of each will be presented, beginning with the acyanotic types

Acyanotic Types of Defects

Patent Interventricular Septum —This defect is the most common congenital lesion to be recognized clinically. It consists of an opening in the septum just below the aortic valve. Because of a normally stronger left ventricle during systole, some of the oxygenated arterial blood in the left chamber is shunted through the opening to the right ventricle, this blood becoming reoxygenated in the pulmonary circuit. Because there is no venous blood in the systemic circulation, there is no cyanosis

The characteristic clinical signs of this lesion are a loud rough systolic murmur with maximum intensity at the third or fourth interspaces to the left of the sternum (Fig 2), transmitted all over the precordium and heard even in the back between the scapulae A thrill frequently accom-

LOCATION OF MURMURS

Congenital Heart Defects

Sub Aortic Stenosis

Defects

Sub Aortic Stenosis

This intervent tricular septime

This intervences

This intervences

This indicate the present

Cyanosis may or may not be present

Acquired Heart Disease

Aortic Stenosis

Aortic Stenosis

Notice that except in oortic stenosis the murmurs of congenital heart defects occupy entirely different congenital heart defects occupy entirely different positions from those of Acquired heart lessions

Fig 2

pames the murmur The intensity of the murmur is in inverse proportion to the size of the septal opening, the larger the defect, the softer the murmur The pulmonic second sound, P2, is accentuated

X-ray examination reveals nothing pathognomonic Usually, the heart is normal in size and shape, although occasionally it appears slightly enlarged The electrocardiogram and blood picture are normal

This condition cannot be corrected by surgery The general prognosis, however, is good

Patent Ductus Arteriosus (Fig 3) —This defect is due to the failure of closure of the fetal vessel connecting the pulmonary artery and the aorta Here again because of the stronger left ventricle, blood is shunted across from the aorta to the pulmonary circulation, and, thus, no cyanosis is present

The most characteristic diagnostic sign is the murmur, which is so typical of this condition that, once heard, it is never forgotten. It consists of a loud, continuous systolic murmur, crescendo and decrescendo in type with its peak at the second heart sound. The point of maximum intensity is at the second left interspace (Fig. 2) and is transmitted to the neck and back. It is described frequently as being machinery, humming top, or whirlpool sounding in character and is often, but not always, associated with a thrill

The x-ray is usually characteristic in that the heart is either normal in size or slightly enlarged with a distinct prominence of the pulmonary aorta. This feature, however, is frequently absent.

Because of the increased amount of blood in the pulmonary arteries, the fluoroscope may show a so-called hilar dance, due to pulsating vessels in the hilus of the lung

The electrocardiogram and blood picture are normal The prognosis is good. This is one type of defect which is amenable to surgery

Aortic Coarctation (Fig 4)—An abrupt narrowing of the aorta usually just distal to the insertion of the ligament of the ductus arteriosus comprises aortic coarctation. It is not rare but is infrequently diagnosed, because signs and symptoms do not, as a rule, appear until adolescent or adult life. These signs, in turn, are due to an extensive collateral circulation from the internal mammary and intercostal arteries to the lower extremities.

Diagnosis depends upon discovering the following characteristics

1 Hypertension occurring in children or young adults with decreased blood pressure in the lower extremities Normally, the pressure is much higher in the legs than in the arms

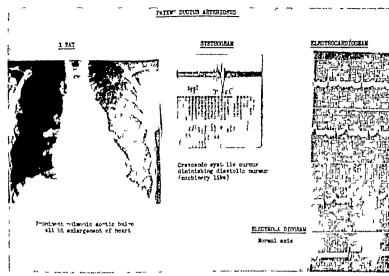


Fig 3

- 2 The iliac and femoral pulse are weak or absent.
- 3 Dilated and pulsating collateral vessels of the chest
- 4 A harsh systolic murmur at the base of the heart and over the back.
- 5 \ ray reveals a notching of the ribs with absence of the nortic knob. The former is pathognomen.

The general prognosis is good This condition can be corrected by surgery

Subscrite Stenors.—This is a very uncommon condition and is the result of a developmental anomaly which produces a narrowing of that part of the left ventricle situated immediately below the aortic cusps. The valves themselves are not involved and the stenosis does not as a rule, interfere with the normal egress of blood from the left ventricle. Therefore, except for the murmur none of the peripheral signs or symptoms of ac quired aortic stenosis are present. The systolic murmur is loud and rough, associated with a thrill, it is beat heard over the second right interspace (Fig. 1) and is transmitted to the neck.

The x ray and electrocardlograph are normal Prognosis is good This is not amenable to sur gery

Cyanotic Types of Defects

Pulmonary Stenosis (Fig 5) -This defect is

most often part of that well-defined entity known as the tetralogy of Fallot, which consists of four components stenosis to atresia of the pulmonary artery a patent interventricular soptum, dextroposition of the norta, and hypertrophy of the right ventricle. It is the most common combination of defects to be found in the so-called 'blue baby'



Fig 4 Aortic coarctation in a twolve-year-old boy Note notching of ribs on right side absent aortic knob and dilated internal carotid artery on left side.

PULLONARY STENOSIS (TETRALOGY OF FALLOT)

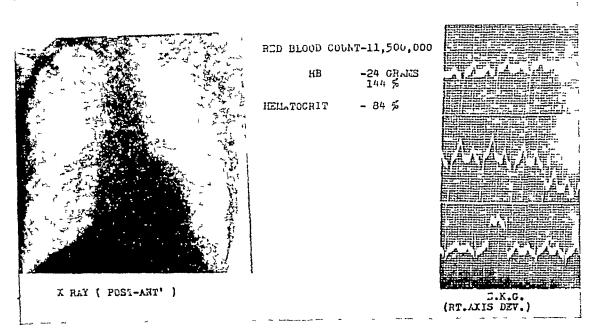


Fig. 5 Normal-sized heart with absent pulmonary bulge

In this syndrome both conditions whichmake for cyanosis are present. The stenosed pulmonary artery prevents the blood of the right ventricle from going to the lungs, and the large septal lesion permits a constant admixture of venous blood in the arterial chamber. During systole, because of the hypertrophied right ventricle and the aorta over-riding the right chamber, the venous blood is being directed into the arterial stream, the result being an early, and usually intense, cyanosis with clubbing of the fingers and toes.

The stenosis produces a loud systolic murmur over the second left interspace (Fig 2) and a softer, more blowing murmur along the border of the sternum because of the septal defect. The pulmonary second sound, P2, is diminished or absent

The electrocardiogram shows a marked right axis deviation. The x-ray reveals the coeur en sabot or boot-shaped heart due to the enlarged right heart, elevating the apex of the left ventricle producing a double apex. The heart itself is normal in size or only moderately enlarged with a characteristic absence of the pulmonary arch Because of the pulmonary stenosis, there is a deficient circulation in the lungs and, therefore, an unusual absence of pulsations in the hilar vessels. This is entirely different from the hilar dance of the patent ductus arteriosus. The blood picture

shows a marked increase in the number of red blood cells with a very high hemoglobin content

The general outlook is poor However, surgery increases the pulmonary circulation and produces a most miraculous relief to the patient

Large Patent Interventricular Septum —In this case signs and symptoms depend upon the size of the defect The larger the opening, the greater the tendency to admixture of venous blood in the left chamber with consequent increased cyanosis and clubbing The systolic murmur also varies The smaller the openwith the size of the lesion ing, the louder the murmur and vice versa the larger defects there is a soft systolic murmur along the sternum without a thrill being present The x-ray reveals a large bottle-shaped heart with no distinct pulmonary bulge The electrocardiograph shows a right axis deviation general prognosis is fair

In the patent interauricular septum defect, there is a flow of blood from the right auricle to the left auricle, producing cyanosis and clubbing Because of poor contractile power in the auricles, only a soft murmur, at best, may be heard at the base X-ray of the heart shows a large pulmonary artery, probably a larger pulmonary convexity than in any other of the congenital lesions, together with enlarged lung hilar shadows. The electrocardiograph shows a right axis deviation. This condition frequently is associated with a

Nother the patent interventricular nor the interauricular septal defects can be remedied by

Burger

The Eisenmenger Complex —This is somewhat amiliar to the tetralogy of Fallot except that there is no stenosis of the pulmonary arters. The large patent interventricular septum over riding aorta and hypertrophied right ventricle are sufficient cause for a delayed cyanosis and clubbing. There is a soft systolic murmur over the sternum with an accentuated pulmonic second sound. On the contract of the pulmonary area due to hypertrophy of the conus and dilatation of the pulmonary artery. The hilus shadows are in creased and show a hilar dance. Right axis deviation is present.

This condition is not common and the progno-

sis is fair Surgery is of no avail

Transpontion of the Great Vessels—This defect is probably the most frequent congenital cardiac condition causing death in early infancy. In this case the aorta arises from the right ventricle and the pulmonary artery from the left

When associated with other cardiac defects life

may be prolonged slightly. In the pure type of disorder no arterial blood reaches the systemic circulation, and the infant is intensely cyanotic from birth. Life is inevitably brief. A case of this type may be suspected when the infant is markedly cyanotic from birth and no murmurs are heard. Clubbing is usually absent. The x-ray reveals nothing unusual, and the electrocardiograph shows a right axis deviation. Surgery is of no value.

Summary

Realizing the necessity of a better recognition of congenital heart defects. I have presented a simplified plan for the differential diagnosis of the more common types of these defects. By dividing the conditions into two groups those without cyanosis and those with cyanosis, the various types of defects can be arranged systematically Under these general headings four lesions of the acyanotic and four of the cyanotic are discussed briefly with important points of differentiation presented. Those defects which may be relieved or corrected by surgery are stressed.

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GLUTAMIC ACID

In several articles recently published in popular periodicals experimentation with glutamic acid has been strongly exploited emphasizing its effects in raising general intelligence levels in subnormal periodical. The general public is being well informed of advances in experimental medicine but some of the side effects concerning which the Journal of the American Medical Association has warned repeatedly are less desirable. Even vast amounts of glutamic acid will not enable morons to approach genius over night.

Pressure of 'patient opinion may force physicians to prescribe products still in an early experient of the prescribe products still in an early experient stage. In recent years latent kidney damage appeared from the use of sulfonamide compounds dermatitis and alloride reaction from antibiotics unfavorable reactions from racemic ampletamine sulfate ('bennedrine sulfate) prescribed too frequently or in excessive amounts and toxic reactions from the authorization drugs.

In human subjects the administration of dl-glutamic acid was tried in conjunction with other known anticonvulsant therapy with groups of patients having grand mal potit mal, and psychomotor discharge types of attacks. Psychomotor and petit mal attacks were definitely decreased in frequency and increased mental and physical alertness of patients was observed. Grand mal scinures were unaffected In all cases tolerance to di-glutamic acid hydrochloride was high. Gastrointestinal reaction was minimal and other untoward symptoms absent.

The results thus far reported with glutamic acid in the types of cases mentioned are considered excellent. However experiments are still under way

The truly infractious progress of medicine in recent years has stimulated a public at titude of expectancy that many medical problems now unsolved will soon be fathomed. Inevitably disappointment will rosult in several instances. Most advances result from progressive accretion of knowledge over a number of years. Occasionally what appears to be definite progress turns out to be merely insufficient and uncontrolled experimentation—J.A.M.A. December 27 1047

MICROBIOLOGIC ASPECTS OF SALMONELLOSIS IN CHILDREN

ERWIN NETER, MD, FAPHA, Buffalo, New York

(From the Children's Hospital and the Department of Bacteriology and Immunology, University of Buffalo)

In contrast to typhoid fever, which, as a result of progress made in modern sanitation and the availability of an effective immunizing agent, has become a relatively rare disease, only little has been accomplished in the control of salmonellosis. Renewed interest in the clinical aspects of paratyphoid infections has been stimulated by the investigations into the antigenic structure and ecology of Salmonella organisms 1-4. It is now generally agreed that salmonellosis occurs much more frequently both here and abroad than was suspected even a decade ago. This report deals with the microbiologic aspects of sporadic salmonellosis in children and is based on data obtained from 33 consecutive cases

Bacteriologic Diagnosis of Salmonellosis

Since the clinical syndromes encountered in Salmonella infections are not characteristic enough for diagnosis on clinical grounds only, it becomes imperative to establish the cause of the disease by means of microbiologic studies. The most reliable method available is the isolation and identification of Salmonella organisms from the patient. The recovery of paratyphoid bacilli from blood, pus, and urine does not present serious difficulty.

The isolation of Salmonellae from feces, however, is somewhat more complicated culties encountered in bacteriologic examination of fecal specimens have been largely overcome by the use of the rectal swab technic and the introduction of selective culture media, which suppress the growth of the saprophytic bacilli and support the growth of the pathogens nella-Shigella (SS) agar (Dico Laboratories), desovycholate-citrafe agar (Baltimore Biological Laboratories), Kauffmann's brilliant green agar, and, for certain strains at least, bismuth-sulfite agar yield a substantially higher percentage of positive isolations than the old-fashioned differential culture media, such as Endo agar tion, the fecal specimen should be placed in an enriching fluid It is essential that the specimen be seeded on the culture media immediately after it has been procured. Otherwise, it should be placed in a preserving fluid

In order to be able to furnish the clinician as soon as possible with a preliminary diagnosis, nonlactose-fermenting colonies may be seeded

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into triple sugar iron agar, Neter's 1 per cent lactose-5 per cent sucrose-1 per cent salicinphenol red broth, tryptophane, and urea media and used for serologic identification with a multivalent Salmonella serum Alternatively, the serologic identification may be accomplished on the following day by using the organisms grown on the triple sugar iron agar slant diagnostic Salmonella serum is being supplied by the Division of Laboratories and Research, New York State Department of Health experience, this serum causes rapid agglutination of the vast majority of Salmonella strains must be emphasized that for the final identification of any isolated strain, the cultural and biochemical characteristics must be established and a detailed antigenic analysis must be carried out Since the determination of the precise type of a strain requires the use of a number of typing sera and can be carried out only in specially equipped laboratories, all strains isolated in this laboratory are being forwarded to Dr Erich Seligmann, New York Salmonella Center, as well as to the Division of Laboratories and Research, New York State Department of Health

Incidence of Salmonella Types

Table 1 summarizes the data on the distribution of the various Salmonella types, encountered in 33 consecutive cases of salmonellosis in children between March, 1943, and March, 1947 For the sake of comparison, the respective figures compiled from Seligmann's series are included ²

It is worthy of note that in the present series not a single case of S paratyphi A infection was encountered S typhimurium was responsible for disease in more than half of all cases Group B, represented by 4 different types, accounted for approximately two thirds of all infections. It is also of interest to point out that members of group D were isolated less frequently than those of either groups C or E

Included in the series are 2 instances of salmonellosis due to rather unusual types, namely, a case of enterocolitis in a sixteen-day old infant, due to the London type, and a case of enterocolitis in a four-month old baby, caused by the St Paul type During April, 1947, S newington was isolated from a seven-day old infant suffering from colitis

In order to establish the incidence of the various Salmonella types presently encountered in

TABLE 1 -- Type Distribution of Salmonella Strains in 33 Cases of Salmonellosis in Children

Group	Туре	Number of Cases	Series of Seligmann et. el
A		0	Ca. 0.7 per cent
В	B. schottmuelleri)	Ca. 5 per cent
_	8, typhimurium	10 (ca. 57 per cent) 3 (ca. 69 per cent)	Ca. 27 per cent
	8. ap. (Derby type)	1 (o (one or por orac)	Ca. 3 per cent
	S ap (St Paul type)	<u>I</u> ,	Ça. 0.2 per cent
С	8. cholernesnis	3)	Ça. 5 per cent
	6 sp. (Montevideo type)	1 } 5 (ca. 15 per cent)	Ca. 5 per cent
_	8 sp (Barellly type)	1)	Ca. 2 per cent
D D	S. sp. (Panama type)	1 1 (ca. 4 per cent)	Ca. E per cent
E	8 ap. (London type)	1 4 (cs. 12 per cent)	Ca. 0 25 per cent Ca. 6 per cent
I	8. anatis	3) · · · · · · · · · · · · · · · · · · ·	Car o bet cons

TABLE 2.-PERTINENT FINDINGS IN 6 CARES OF SALMONELLA BACTERENIA

Are of Patient	Clinical Findings	Type of Salmonelia	Outcome
21/1 years	Sepsis and osteomyelitis Bacteremia complicating	8. typhimurium	Recovered
7 years		8 choleraesula	Recovered
10 years	meningococcie meningitis Bacteremia con plicating	S. choleraesula	Recovered
4 months	streptococcie sore throat Enterocolitis Enterocolitis Beyels and meningitis	S. typhimurium	Died
5 months		S. typhimurium	Died
4 years		S choleraceuls	Died

western New York, this study should be extended to ambulatory patients, food handlers, contacts of patients, and to healthy individuals and it should be supplemented by reports from other laboratores

Blood Cultures —Blood for cultural examina too was obtained from 12 patients —Six of these blood cultures were positive for Salmonella and 6 were sterile —Table 2 summarizes the pertinent findings in the 6 cases of Salmonella bacteremia

Mention may be made of the fact that in 2 of these cases the Salmonella infection occurred concurrently with, or as a sequela to, another malady namely meningoroccic meningitis and streptococcic sore throat. The relationship between simultaneously existing salmonellosis and other maladies has been discussed recently **

If the last with the diagnosts of acute the fifth to eight day of the malady salmonellosis. Antibodies usually do not appear before the fifth to eighth day of the malady hegative results may be obtained even in the presence of specific agglutinins, if suitable Salmonella suspensions are not employed.

In the present series Widal tests were carried out on serium specimens from 16 patients. Significant agglution titers were obtained in 7 instances. Indubitably, a higher percentage of positive results would have been obtained had serologic examinations been made repeatedly over a period of one to three weeks

In order to render the Widal test of greater value, diagnostic laboratories should have available, as antigens those types or representatives of groups of Salmonellae encountered in a particular area at a particular time. Obviously such antigens must be tested with respect to their agglu

tinability by sera of healthy individuals as well as of patients suffering from salmonellosis and other maladles Several such antigens have been prepared in this laboratory and are now included in the Widal test

Scasonal Distribution—The data on the sea sonal distribution of the present cases has been summarized in Table 3. It is evident that there is no seasonal peak during the summer months in fact, 16 cases were observed during the warmer season between May and September, while 17 cases were observed between October and April

TABLE 3 -- SEASONAL DISTRIBUTION OF \$3 SALMONELLOSIS

Number of Cases
8 1
3
8 0
2 2 2

Age Distribution —The age distribution of the patients is recorded in Table 4. It is worthy of note that of the 33 cases 23 or approximately 70 per cent, were one year old or less including 9 under the age of three months. The youngest patients were respectively, twelve and sixteen days of age at the time of the onset of the illness. During April, 1947, salmonellosis in a seven-day old infant was encountered

The fact that Salmonella infection was seen predominantly in infants need not necessarily be

NEUROLOGIC PROCEDURES IN PEDIATRIC PRACTICE

Bronson Crothers, MD, Boston, Massachusetts

(From the Children's Hospital, Boston, Massachusetts)

THE pediatrician is committed to an ambitious program which cannot easily be realized effect, he claims that he is a general practitioner for an age group He can readily subtract a few of the responsibilities of the practitioner among No one expects him to conduct obstetric procedures or to supervise the degenerative diseases of elderly people On the whole he does not need to concern himself with the hazards involved in industrial occupations To compensate for these considerable concessions he needs to acquire special skills in regard to the problems Through necessity he must adapt the technics of numerous specialists to his special In this discussion I wish to suggest methods by which he can select neurologic skills for his purposes

Everyone is vaguely aware of the fact that traditional medical nomenclature is based on The two special groups which Greek and Latin have retained traditional language are the dermatologists and the neurologists, and it is easy to see why they find this convenient On the whole, both specialties developed in a time when syndromes were reliable, because treatment or modification was difficult It is, of course, true that continuous progress is being made, but the description and identification of reliable syndromes is still an interesting, useful, and highly sophisticated occupation

In pediatric practice degenerative disease is of negligible importance, and one of the least valuable assets to a pediatrician is an ability to identify Charcot-Marie-Tooth progressive muscular atrophy of adolescence or Tay-Sachs' amaurotic family idiocy. The problems of children, particularly those of young children, are largely due to processes which threaten orderly growth rather than to those which are accompanied by degenerative changes.

It is possible, I believe, to meet most of the neurologic, and perhaps most of the psychiatric, problems of children if we start with the pediatrician's chief assets, a competent interest in normal growth and development and concern about deviations from expected progress

A few generalities and definitions may make later discussion less confusing First, the child in our culture is a dependent individual. The activities and the attitudes of the people who,

Presented by invitation at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Pediatrics May 8 1947 rightfully or by usurpation, control or try to control him are factors in establishing his physiologic and psychologic structure

Second, development begins at conception and not at birth

Third, the effect of any lesion which causes distortion of orderly development will be more devastating in proportion as the child is less mature

Fourth, recovery and convalescence are very different in adults and in children. In adults recovery means restitution to an established status, whereas in children it implies unimpaired capacity for development.

The causes of neurologic disease in children are, of course, varied, but they are certainly very different from those in adults. The adult clinics are largely resorted to by patients who have been battered by life's experiences or who are old or are the victims of syphilis. Degenerative disease is rare in children and syphilis of the nervous system, although constantly searched for, is an almost negligible condition in my experience. The major problems are due to a vast variety of infections and to trauma, with a scattering of tumors and a baffling collection of convulsive states and deviations from developmental effectiveness which we cannot yet understand

The way to approach neurologic appraisal is to think in physiologic terms—If anterior horn cells are damaged, abolition of function occurs—If sensory impulses are cut off, the results can be anything from anesthesia to blindness or ataxia to lack of recognition of form

If the cord is transected, the result is isolation of the part of the nervous system below the lesion. If the lesion involves much of the cerebral hemispheres, the result is what amounts to physiologic decerebration with the primitive patterns of behavior which are seen in artificially decerebrate animals.

Cerebellar disorder leads to a series of phenomena, dominated by uncertainty of control, ataxia, dysmetria

Lesions of the basal gangha upset associated movement and produce tremors and athetosis

Finally, cortical lesions produce difficulty in controlling voluntary motion

With the physiologic picture in mind we go on to psychologic appraisal Fortunately, this part of the problem is not confused by evotic vocabulary, and pediatricians, if they are wise, will try to keep up with the parent teacher groups who are supervising patients no longer under medical care.

Finally, the last element is the appraisal of the adults who make such admirable and probably ineffective efforts to control the development of the children for whom they are responsible. The advantage of such a procedure is that it allows the pediatrician to state his idea of deficits and also points out the remaining assets. This certainly is worthwhile, since dectors are dependent on deficits for classification of disease, whereas parents are chiefly interested in assets.

With the physiologic picture in mind, with the psychologic material also defined, and with the adult environment under control, all the pediatrician must do is to plot his prognosis on an ascending scale of development and arrange the necessary modifications of education. In other words, he deals with neurology as part of pediatrics

Recent advances in pediatrics have led to increasing awareness of prenatal development From the neurologic point of view the recognition of German measles in the early weeks of pregnancy, of toxoplasmosis etc., is important. The saving of very young premature bables will prob-

ably result in a new group of blind babies with retrolental fibroplasia and mental defect. Again, the rescue of babies with crythroblastosis will always be perilous. The process of labor will always be perilous.

More and more the specific neurologic problems of children will, I believe, vary from those of adults, and the pediatrician will always have to meet injury and infection and anoxia in the ner

vous system, as well as elsewhere.

The specific tools are familiar to most of us. The ophthalmoscope is within our means, both financially and intellectually. There is no podiatrician who shrinks from lumbar puncture, and from there it is an easy step to the pneumoencephalogram. The electro-encephalogram is, for the moment, in the hands of experts, but only for the moment.

My plea is a simple one. If we recapture a physiologic approach, neurology need be no more forbidding than any other specialty of medicine I think the pediatricians' problems are so different from those seen by adult neurologists that the pediatricians must select rather than wait for a digest from the neurologists

ANNOUNCEMENT

1948 Medical Directory Deadline

All material for the 1948 Medical Directory of New York, New Jersey and Connecticut should be in the office of the Medical Society of the State of New York before April 15, 1948

No corrections or additions may be made after that date

ROUTINE EXAMINATION OF CEREBROSPINAL FLUID

Albert H Harris, M D, and Carl Lange, M D, Albany, New York (From the Division of Laboratories and Research, New York State Department of Health)

CEREBROSPINAL fluid contains the humoral and cellular material which the central nervous system releases into it. Samples of this fluid reveal distinguishable active processes in a variety of pathologic conditions, but they can do so only if optimal methods of examination and interpretation are employed.

Indications for the Examination of Cerebrospinal Fluid -- Manifestations of central nervous system involvement as, for example, in acute febrile meningitis, are usually so significant and often so alarming that the indications for obtaining cerebrospinal fluid are obvious In syphilis, however, the situation is altogether different, since the principal indications are not clinical ones the contrary, definite clinical evidence of neurosyphilis must be prevented, if possible, since symptoms and signs due to neurosyphilis often indicate irremedial damage. The responsibility of the general practitioner in this regard is considerable, for neurosyphilis is believed to begin, if at all, in the early stages of the disease, when the patient is most apt to be under his care active process in the central nervous system needs to be halted by adequate therapy during the asymptomatic stage, which usually lasts an appreciable time before clinical signs supervene

Fluid must be obtained for laboratory examination between six and twelve months after beginning therapy to determine evidence of central nervous system lues. Preferably, a specimen should be submitted both at the six- and the twelve-month stages. If evidence of neurosyphilis exists, a tap must be made at regular intervals as a control of treatment. Following conclusion of general antiluctic treatment, the final examination should be made, at the earliest, twelve to fifteen months after infection, when one may feel reasonably sure that if neurosyphilis is going to develop, indications will already have appeared

In summary, it can be said that compelling clinical signs and symptoms of central nervous system disorder furnish the indications in most diseases of the brain and spinal cord. However, in syphilis, fluid must be examined, not on the basis of clinical manifestations, but according to a time schedule

Method of Obtaining Cerebrospinal Fluid and Certain Precautions to Be Observed—Cerebro-

Presented at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo, Section on Pathology and Chuical Pathology, May 7 1947 spinal fluid, obtained by lumbar puncture, contains cells that have settled by gravity. Therefore, especially in syphilis, slight abnormalities are most readily demonstrated in fluid from the lumbar region.

Every effort should be made to avoid accidental contamination of the cerebrospinal fluid with blood during the puncture. The use of a sharp needle with the patient in a sitting position decreases the possibility of contamination. When such an accident occurs, however, the needle should be withdrawn and a different one inserted in a higher space. The practice of allowing fluid contaminated with blood to flow until visibly clear does not yield an optimal specimen. If, for any reason, a second puncture is impracticable, as clear a specimen as possible should be submitted.

Under no circumstances should the erythrocytes be removed from the fluid in such cases, since their presence, whether intact or hemolyzed, furnishes an indication of the amount of blood contamination. Whether or not useful information can be obtained from such specimens depends on the degree of contamination and the severity of the abnormal changes in the fluid, the less the contamination and the more marked the abnormality, the more apt such specimens are to be of some value.

Likewise, bacterial contamination must be avoided, if possible Spinal fluid pressure measurements are, as a rule, not indicated in syphilis, since they rarely provide information of value They increase the liability to contamination and, therefore, should be omitted

The amount of fluid required for routine examination is from 3 to 5 cc. It should be allowed to flow directly through the needle into a sterile tube. The stopper should be removed just long enough to catch the fluid and should then be replaced. No fluid should be removed with a pipet, especially after the specimen has stood awhile, since the distribution of cells will be uneven, and subsequent counts will be inaccurate. The dipping into the fluid with a cell-counting pipet, containing acetic acid, is a disastrous procedure.

Submission of Cerebrospinal Fluid Together with a Specimen of Blood—Cerebrospinal fluid obtained for bacteriologic examination is best examined in the nearest laboratory approved for bacteriologic procedures, because promptness in examination and reporting is essential in cases of

scute bacterial meningitis However, in the case of spinal fluids that require complicated and exacting technics, as is the case with most of the specimens that are clear and colorless, the specimen should be sent to a central laboratory or to a near-by local laboratory approved for undertaking complete cerebrospinal fluid examinations.*

Unfortunately, some changes can occur in transit Although the round cells are fairly reastant, polymorphonuclear leukocytes and red blood cells are easily lysed. This fact is significant when the fluid contains polymorphonuclear leukocytes in very low concentration, as in early tuberculous meningitis, since their detection is important to the diagnosing of syndrome. Any accidental contamination with bacteria is apt to render a mailed specimen unsatisfactory, since the time interval may encourage bacterial growth.

The submission of an accompanying specimen of blood is important, because, except in cases of acute bacterial meningitis, syphilis almost always enters into the differential diagnosis. While provided a satisfactory quantitative method is used, a specific reaction indicating lues is rarely found in the cerebrospinal fluid when no reaction occurs in the blood, the converse is frequently true, that is, in many syndromes in which the cerebrospinal fluid is abnormal yet fails to react in the quantitative complement fixation test for syphilis, the blood gives a positive reaction, thus indicating the luctic nature of the pathologic process in the central nervous system. Further more, when a diagnosis of neurosyphilis has been established, it is necessary to know the titers of reactions in the complement fixation test on both spinal fluid and blood as a guide to therapy

An outfit containing two tubes, one with a conical base for the cerebrospinal fluid and one of the usual type with needle for the blood specimen, is distributed for submission of specimens to the Division of Laboratories and Research (Fig. 1)

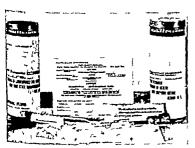


Fig 1 Cerebrospinal fluid and blood outfit.

Submission of History and Clinical Data.—Pertinent facts from the history and clinical data must accompany the specimen, this information is essential for an intelligent interpretation of the findings. In some pathologic conditions of the central norvous system, the laboratory findings add nothing to the understanding of the case. In others, the history and clinical data are not helpful. In the vast majority of cases however, the clinical and laboratory findings must be considered together for as comprehensive an understanding of the case as is possible.

Basic Cerebrospinal Fland Examinations —The types of examinations to be performed, when the specimens of cerebrospinal fluid and blood reach the laboratory, depend upon the history and childed data and on the appearance of the fluid. If the history indicates that the spinal fluid may contain pyogenic bacteria, or if the fluid is purilent, a cultural study is obviously indicated, for example, the presence of a cobweb clot requires

examination for tubercle baculli

Much more challenging to the diagnostic labora tory are spinal fluids that are normal in appear ance, that is clear and colorless. All such fluids require study by 5 basic examinations.

- (1) The appearance is noted as clear and colorless
- (2) A differential cell count is made with particular attention to mononuclear (round) cells, polymorphonuclear leukocytes and erythrocytes. The term mononuclear is used to include all cells other than granulocytes and erythrocytes
- The cells are stained with polychrome methylene blue and are counted in a Fuchs-Rosenthal counting chamber. With this large chamber 3 cu. mm of spinal fluid can be examined and the results can be expressed as the number of cells/3 However the routine report from this laboratory at the present time gives the number of cells per cu. mm. After the cells have been counted the fluid is centrifuged at high speed. The sodiment is then fixed on a glass slide and stained with methylene blue. An examination of this material serves as a check on the cell picture and may demonstrate bacteria that are present either as pathogens or as fortuitous contaminants.
- (3) The total protein concentration is determined by the sulfosslicylic acid method, in which a photoelectric colorimeter is employed
- (4) The colloidal gold test, valuable in differ entiating protein patterns, is performed. The citrate gold sol now employed is carefully stand ardised and checked for sensitivity and reproducibility by turbidimetry and by reactions with a test fluid. This sol has been found superior to the original formal gold sol and the various colloidal substitutes.

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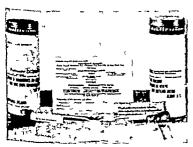
Submission of Cerebrospinal Fluid Together with a Specimen of Blood—Cerebrospinal fluid obtained for bacteriologic examination is best examined in the nearest laboratory approved for bacteriologic procedures, because promptness in examination and reporting is essential in cases of

acute bacterial meningitis. However, in the case of spinal fluids that require complicated and exacting technics, as is the case with most of the specimens that are clear and coloriess, the specimen should be sent to a central laboratory or to a near-by local laboratory approved for under taking complete cerebrospinal fluid examina tions *

Unfortunately, some changes can occur in transit. Although the round cells are fairly resistant, polymorphonuclear leukocytes and red blood cells are easily lysed This fact is signifi cant when the fluid contains polymorphonuclear leukocytes in very low concentration, as in early tuberculous meningitis, since their detection is important to the diagnosing of syndrome. Any accidental contamination with bacteria is apt to render a mailed specimen unsatisfactory, since the time interval may encourage bacterial growth

The submission of an accompanying specuren of blood is important, because, except in cases of acute bacterial meningitis, syphilis almost always enters into the differential diagnosis provided a satisfactory quantitative method is used a specific reaction indicating lues is rarely found in the cerebrospinal fluid when no reaction occurs in the blood, the converse is frequently true, that is, in many syndromes in which the cerebrospinal fluid is abnormal yet fails to react in the quantitative complement fixation test for syphilis, the blood gives a positive reaction, thus mdicating the luctic nature of the pathologic process in the central nervous system. Further more, when a diagnosis of neurosyphilis has been established, it is necessary to know the titers of reactions in the complement fixation test on both spinal fluid and blood as a guide to therapy

An outfit containing two tubes, one with a conical base for the cerebrospinal fluid and one of the usual type with needle for the blood specimen, is distributed for submission of specimens to the Division of Laboratories and Research (Fig 1)



Ccrebrospinal fluid and blood outfit.

Submission of History and Clinical Data .-Pertinent facts from the history and chincal data must accompany the specimen, this information is essential for an intelligent interpretation of the findings. In some pathologic conditions of the central nervous system, the laboratory findings add nothing to the understanding of the case In others, the history and clinical data are not In the vast majority of cases, however, the clinical and laboratory findings must be con sidered together for as comprehensive an under standing of the case as is possible

Basic Cerebrospinal Fluid Examinations -The types of examinations to be performed, when the specimens of cerebrospinal fluid and blood reach the laboratory depend upon the history and clinical data and on the appearance of the fluid If the history indicates that the spinal fluid may contain pyogenic bacteria, or if the fluid is puru lent, a cultural study is obviously indicated, for example, the presence of a cobweb clot requires examination for tubercle bacilli

Much more challenging to the diagnostic labora tory are spinal fluids that are normal in appear ance that is, clear and colorless. All such fluids require study by 5 basic examinations 1

- (1) The appearance is noted as clear and colorless.
- (2) A differential cell count is made with particular attention to mononuclear (round) cells, polymorphonuclear leukocytes and erythro-The term mononuclear is used to include all cells other than granulocytes and erythrocytes
- The cells are stained with polychrome methyl ene blue and are counted in a Fuchs-Rosenthal counting chamber With this large chamber 3 cu mm. of spinal fluid can be examined and the results can be expressed as the number of cells/3 However, the routine report from this laboratory at the present time gives the number of cells per After the cells have been counted the The sediment fluid is centrifuged at high speed is then fixed on a glass slide and stained with methylene blue. An examination of this material serves as a check on the cell picture and may demonstrate bacteria that are present either as nathogens or as fortuitous contaminants
- The total protein concentration is deter mined by the sulfosalies he acid method, in which a photoelectric colorimeter is employed
- (4) The colloidal gold test valuable in differ entiating protein patterns, is performed citrate gold sol now employed is carefully stand ardised and checked for sensitivity and reproducibility by turbidimetry and by reactions with n test fluid This sol has been found superior to the original formol gold sol and the various col lordal substitutes.

TABLE 1—Results of Cerebrospinal Fluid Examinations—Examples of Typical Findings
Turbid of Colored Spinal Fluids (Abnormal Appearance)

No	Clinical Data	Appearance	Cell Pi Mono- nuclears	cture* Poly- morpho- nuclears	Total protein (Mg/100 Cc)	Bacteriologic Examination	Interpretation from the Complete Syndrome
1	Acute febrile meningitis	Purulent, slightly yellow, coarse branching clot	87/3	3400/3	548	Culture hemolytic streptococci	Streptococcus meningitis
2	Vague signs of meningstus	Ground glass,' trace of yellow, cobweb-like clot	186/3	534/3	274	Ziehl-Neelsen stain of fibrin elot acid-fast bacilli seen	Chronic tuberculous meningitis
3	Fracture of vertebra with com- pression	"Froin's syndrome ic., xanthochromia complete coagulation	2/8	0/3	1450		Subarachnoid block

^{*} Fractions indicate the number of cells in the 3 cu mm. examined. In routine reports issued by the Division of Laboratories and Research cell counts are being expressed in the number per cu mm. to the nearest integer

The reaction of the gold sol with the serial dilutions of cerebrospinal fluid must be permitted to take place in a medium in which the pH and ion concentration have been carefully adjusted

(5) A quantitative complement fixation test for syphilis is essential, and, as has already been stated, it must be performed not only on the cerebrospinal fluid but also on an accompanying specimen of blood.² Unless the complement fixation test employed is quantitative, and unless it is high in sensitivity, specificity, and reproducibility, the results will be of inferior value

Typical Examinations and Findings

Specimens Exhibiting an Abnormal Appearance (Table 1)—The choice of examinations is determined by the appearance of the cerebrospinal fluid Fluids exhibiting an abnormal appearance are handled on an individual basis Determination of the cell picture and the total protein is routine, but other procedures, such as a microscopic examination of the sediment stained by Gram's method, culture in appropriate media, and animal inoculation, are performed as indicated by the particular specimen under examination

Specimen 1, a purulent spinal fluid from a case of acute febrile meningitis, required a bacteriologic examination, no bacteria were seen in the stained sediment, but hemolytic streptococci were isolated on culture

In specimen 2, the cobweb-like fibrin clot indicated an examination for tubercle bacilli, stained with Ziehl-Neelsen stain, acid-fast bacilli were found. When the history or appearance of the specimen suggests bacterial meningitis, appropriate bacteriologic examination generally furnishes a specific diagnosis. Under such circumstances, other types of examination are of relatively little significance in the interpretation of the complete laboratory findings.

Specimen 3 furnishes an example of From's syndrome complete coagulation and xantho-chromia When it is present, the appearance of

the fluid alone is pathognomonic of subarachnoid Contrary to the syndromes of specimens 1 and 2, From's syndrome does not provide a final diagnosis, since block is merely a complication due to compression or adhesions associated with a fundamental pathologic process From's syndrome is elicited by a pachymeningitis cervicalis syphilitica, for example, the luetic nature of the process cannot be determined by examination of the lumbar cerebrospinal fluid, since it is so heavily contaminated by infiltrating blood proteins that the basic picture is obscured The syphilitic cause of the meningitis can only be demonstrated by an examination of the cisternal fluid, which, in the absence of plasma proteins. will yield results in the five basic tests that are due only to the local process in the central nervous system

Specimens Exhibiting a Normal Appearance (Table 2)—Cerebrospinal fluids exhibiting a normal appearance fall into a different category. They form the major portion of the routine material in a laboratory performing complete examinations of spinal fluid. Contrary to abnormal appearing fluids, which are considered on an individual basis, all fluids that are clear and colorless are subjected to the five basic examinations.

Of these five, only the quantitative complement fixation test for syphilis can, by itself, yield information of etiologic value. However, even though a significant reaction in the complement fixation test for syphilis, performed on the spinal fluid, is indicative of syphilis, it does not prove local origin of the reagin. Information in this regard is furnished by the nonspecific colloidal gold reaction which demonstrates the presence or absence of plasma proteins in the spinal fluid, thereby establishing or excluding the possibility that some or all of the reagin is of hematogenous origin.

The nonspecific gold reaction also serves to differentiate the parenchymatous and nonparenchymatous forms of neurosyphilis. In the examination of spinal fluids from cases of multiple

CLEAR, COLORLESS SPINAL PLUIDS (NORMAL APPEARANCE) TABLE 1—RESULTS OF CRRESSOSTINAL FLUID EXAMINATIONS—EXAMPLES OF TYPICAL FINDINGS

		570 New Designation of type Test from the Complete	Type / Normal gold reac- Sy	of cure of Type B Syphilitic 17 Asymptomatic non parently matters are non parently matters	"1/1 Type B "Syphilido Neurorius infection	14 Type C Meninglie" Syndrome encountered in early nerroritation in the control of the	2 Type C "Venlagie", Asente meninglis of	Parette" 05 260 Neurosyphilis Parenchymatons 05 260 marked	and the state of t	(weak) Parenchymatous (reak) releveds
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Cell Pfeure*			ដ			5	2	8	12	5
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Exciton indicate the number of sulls in the 3 cm mm, examined. In routine reports issued by the Dirivion of Laboratorics and Research, cell counts are being expressed in the

sclerosis, the only positive results are nonspecific ones

When the results of the five basic tests are integrated, however, and are viewed in the light of clinical data, a characteristic syndrome emerges. Thus, although specific and nonspecific tests provide entirely different types of information, in a majority of instances both are indispensable to the establishment of a complete syndrome

Specimen 4 yielded the syndrome of normality, characterized by normal values in each of the five basic examinations. Most important among the findings were the normal protein concentration and the normal colloidal gold curve type A. This particular syndrome was found in a case of paresis treated with penicillin. It demonstrates cure. So far, no relapse has been reported in cases in which the cerebrospinal fluid furnished values so completely normal.

Specimens 5 and 6 elicited the colloidal gold curve type B, formerly designated as the "syphilitic" curve. This curve reflects the type of protein pattern resulting from disintegration of numerous cells shed into the cerebrospinal fluid, occupying perivascular spaces during the active stage of diseases in which perivascular infiltration is a cardinal feature. The curve is encountered in neurosyphilis, multiple sclerosis, and in the stage of recovery from an acute virus infection.

In specimen 5 the history of syphilis, the abnormal cell count and increased total protein, and the gold curve type B, are indicative of nonparenchymatous neurosyphilis, the reaction in the complement fixation test of the blood, despite the absence of reaction in the cerebrospinal fluid, supports a diagnosis of neurosyphilis

In specimen 6 the abnormal cell count, increased total protein, and gold curve type B were not accompanied by any reaction in the complement fixation test for syphilis on either spinal fluid or blood. The history stated that the fluid had been obtained three weeks after the acute stage of mumps. In the absence of any evidence of significant parenchymatous involvement, one could anticipate that later examinations would reveal the syndrome of normality.

Specimens 7 and 8 elicited the colloidal gold curve type C, formerly designated as the "meningitic" or "hematogenous" curve This curve is found when there is abnormal communication between blood and cerebrospinal fluid, resulting in a seepage of blood proteins into the cerebrospinal fluid. In syphilis, blood reagin may thus filter into the spinal fluid, confusing the pathologic picture. The type C curve is found in evudative inflammation, in the acute initial stage of virus infection, in subarachnoid block, and in hemorrhage. It is not encountered in chronic

neurosyphilis, as long as the permeability remains

In specimen 7 the marked increases in mononuclear cells with occasional polymorphonuclear leukocytes and in the total protein concentration, together with a strong colloidal gold curve type C, are compatible with the physician's clinical diagnosis of encephalitis lethargica. Similar findings may occasionally be observed in tuberculous meningitis. However, no bacteriologic evidence of this latter disease was found in this particular fluid. As often happens in the acute phase of illnesses presenting similar pictures, the final diagnosis awaited a follow-up examination which is described under specimen 11

In specimen 8 an increase in mononuclear cells, the presence of polymorphonuclear leukocytes, and the colloidal gold curve type C are in marked contrast to the protein concentration, which is in the low normal range. In spite of the normal protein values, the cell picture and gold curve establish a syndrome of exudative inflammation, in this case indicating an aseptic meningitis of minimum degree, undoubtedly induced by the mastoiditis. Such findings are not prognostic Follow-up examinations may reveal decreasing inflammation or an overnight change in the picture to one of purulent bacterial meningitis.

Specimens 9, 10, and 11 elicited the colloidal gold curve type D, formerly designated as the "paretic" or "parenchymatous" curve This curve is associated with inflammatory processes similar to those that induce the type B curve, except that, in addition, there is more or less extensive parenchymatous degeneration, which may or may not be clinically apparent Because this type D curve is regularly found when late clinical signs point to degeneration of the parenchyma, from the practical standpoint of prognosis and therapy the curve is generally considered by syphilologists to indicate such degeneration before clinical evidence of it becomes manifest

Syndrome 9 is the so-called paretic formula, more properly a strong syndrome of parenchymatous neurosyphilis. The syndrome is characterized by a marked increase in round cells and in the total protein concentration, a strong colloidal gold curve type D, and high titers in the complement fixation test for syphilis with both spinal fluid and blood

In syndromes 10 and 11, the cell picture, the total protein concentration, and the protein pattern as reflected by the gold curve are all similar to those in syndrome 9. The histories are altogether different, however, and there is absence of complement fixation reaction in both cerebrospinal fluid and blood.

Syndrome 10 is typical of progressing multiple sclerosis—the active inflammation is indicated

by the abnormal cell and protein findings, the progressive parenchymatous degeneration is reflected in the gold curve type D These findings are sufficient to confirm the clinical diagno-

Syndrome 11 was encountered in cerebrospinal fluid from the same patient as specimen 7, three months later Cells and total protein had decreased considerably, while the gold reaction which was type C during the acute initial stage, was now type D indicating parenchymatous degeneration. The possibility of tuberculous meningitis, which previously entered into the differential diagnosis, was excluded by these latter findings They indicate that the chinical diagnosis of encephalitis lethargica was correct and that the disease had passed into the chronic phase

Conclusion

In conclusion, the following points are reemphasized Cerebrospinal fluid is precious and deserves examination by the best methods available. The significance of results varies in differ ent conditions In some cases, the laboratory examination furnishes the diagnosis in others, the clinical findings are sufficient. In most cases however, the diagnosis is made on the basis of the clinical and laboratory findings considered together as a complete syndrome

The results of laboratory examinations also serve as a guide in prognosis and therapy the least important is the fact that they may establish the normality of a specimen of cerebrospinal fluid which in treated neurosyphilis provides the demonstration of cure.

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* SANITARY CODE Chapter II

Regulation 9 Physician to submit specimens for labora tory examination in cases or suspected cases of certain com municable diseases. A physician in attendance on a person affected with or suspected of being affected with any of the diseases mentioned in this regulation shall submit to an approved laboratory or to the laboratory of the state department of health for examination such specimens as may be designated by the state commissioner of health, together with data conserning the history and clinical manifestations per tinent to the examination ayphilis

Directions Governing Submission of Specimens

Syphilis

4 When central nervous system ayphills is suspected or before any syphilitic patient is discharged as arrested or cured 5 ml, of cerebrospinal fluid for the complement fixation (Wassermann) test and other tests for abnormalities. Send with each specimen of cerebrospinal fluid 10 ml. of the pa tient a blood taken at the time the specimen of cerebrospinal fluid was obtained for examination (outfit for blood and cerebrospinal fluid) (Effective December 17 1945)

SERIOUS DOG SHORTAGE IN MEDICAL RESEARCH

A critical nationwide shortage of laboratory animail, particularly dogs, for medical research has been highlighted by an announcement from the University of Denver that two scientists Drs. F D Amour and F R. Blood have developed technics for wide. wider use of rats in experiments and instruction

Since rats cannot replace dogs for many experi-ments, however there looms an increasingly urgent need for more experimental dogs in the great medi-cal centers of the country The shortage of dogs is attributed to several factors among them the fact that the dog population of the nation is not increasing and apparently is being materially reduced by the programs of the antivivisectionist cult. In one large city more than thirty thousand dogs are killed each year by antivivisectionist societies according to sta tistics released by them

The increasing cost of specially bred laboratory does is placing a strain on medical research budgets. It now is estimated that it costs at least \$25 to raise a dog from a pup to the point where he can perform his

valuable part in medical research

In expanding the role of the rat in teaching and research the Donver doctors have belped to relieve the principal research bottleneck but there are many types of experiments for which rats are basically un-suitable.—National Society of Medical Research January 16 1048

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BACILLUS PROTEUS MENINGITIS

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BACILLUS proteus, formerly regarded as a harmless saprophyte, is now known to be pathogenic. It has been recognized as the causative agent in various infections. Pierson and Honke reported an incidence of 12 per cent in their series of urinary tract infections. Epidemic gastrointestinal diseases are caused often by consumption of meat decomposed by these organisms, and B proteus has been isolated in summer diarrhea of children. It has been frequently reported as the primary infective agent in cases of acute and chronic middle ear and mastoid infections.

Our interest in this subject was aroused on the recovery of B proteus from the cerebrospinal fluid both during life and from the mastoid on postmortem examination

The members of the genus proteus are gram-negative organisms, highly pleomorphic and subject to great variation in size. Taylor identified 53 strains isolated from varied human sources, of these he classified 22 as definitely pathogenic, 24 as nonpathogenic, and 7 as of doubtful pathogenicity. Bergey classifies 8 species of the genus proteus. McKee states that Proteus vulgaris and mirabilis are the most important members of the proteus group from a clinical standpoint.

McKee reviewed the literature and noted 18 cases of B proteus meningitis reported up to the year 1941. Of these cases, one (that of Neal and Abramson) was a mixed infection caused by Staphylococcus aureus and B proteus. This case is excluded from our review. We add the case of Ohlmacher (1897), which is the first case reported in the literature, and 3 additional cases, those of Meltzer, Sugar, and Myers. This makes a total of 21 reported cases to date. (See Table 1)

The table reveals that 13 of the 21 cases were secondary to otitis media. Almost all of these were chronic otitis media of long standing with recurrent

episodes of purulent discharge. In 7 of the cases tabulated, the focus from which the meninges were infected could not be determined. One case was secondary to a B proteus peritonsillar abscess.

Seven of the cases had other complications Bacillus proteus septicemia occurred in four, in one of which there was a liver abscess as well. The other three developed B proteus brain abscesses

The mortality rate of all cases reported to date is 76 2 per cent

Case Report

This was the first Lincoln Hospital admission of a 54-year-old Italian housewife to the surgical service for pain in the left ear and left postauricular region. The patient claimed she had suffered from pain and discharge from the right ear since infancy. During the week prior to her admission, the pain became sharper and more unbearable. She refused sulfonamide medication prescribed by her physician and took codeine for relief from pain. She fainted

on the morning of admission to the hospital Physical examination showed a well-developed, obese, white woman in a semistuporous condition On admission the temperature was 102 2 F, pulse 100 per minute, respirations 26 per minute, blood pressure 180/70 The white cell count was 19,500 per cm with 85 per cent polymorphonuclears. There was exquisite tenderness over the left mastoid region, marked nuchal rigidity, and drooping of the left side of the mouth. The left pupil was larger than the right. Both reacted sluggishly to light and accommodation. There was moderate ptosis of the left upper hid. Examination of the right drum revealed no abnormality. The left drum was perforated and a thick, creamy, yellow discharge covered its surface. The normal landmarks were obliterated.

No pathologic reflexes could be elicited All the deep reflexes were somewhat exaggerated. The remainder of the physical examination revealed no unusual changes

TABLE 1 -Data from 21 Cases of B proteus Meningitis on Record

	=======			
Observer	Year	Cause	Complications	Result
Ohlmacher4	1897	Otitis media	Brain abscess	Died
Ross ¹⁰	1912	Otitis media	None	Died
Goebel ¹¹	1914	Undetermined	None	Died
Bauer ¹²	1918	Otatis media	None	Died
Anderson ¹³	1921	Undetermined	None	Died
Anderson ¹³	1921	Undetermined	None	Recovery
Kernan ¹⁴	1922	Peritonsillar abscess	Brain abscess	Died
Bischoff and Brakenfeld ¹⁵	1925	Undetermined	None	Died
Bewley and Horgan ¹⁶	1927	Undetermined	None	Died
Neal and Abramson	1927	Undetermined	None	Died
Kortenhaus ¹⁷	1930	Otitis media	Septicemia	Died
Paginer ¹⁸	1932	Undetermined	Septicemia	Died
Cathala and Gabriel ¹⁹	1933	Undetermined	None	Died
Pangalos and Doucas**	1935	Otitis media	None	Died
Calhoun ²¹	1936	Otitis media	None	Recovery
Mouquin ²²	1939	Otitia media	None	Recovery
Neter ²³	1940	Otitis media	Septicemia	Died
Cragg ²⁴	1941	Otitis media	Septicemia and liver abscess	Recovery
Meltzer ⁷	1941	Otitis media	Brain abscess	Died
Sugar ^s	1944	Otitis media	None	Died
Myera*	1944	Otitis media	None	Recovery

The clinical diagnoses on admission were acute and chronic left otitls media, scute purulent men-

ingitis and left occulomotor and facial paresis.

Examination of cerebrospinal fluid showed turbid, greenish-yellow fluid under 280 mm HrO pressure. It contained 392 cells per cm. 95 per cent of which were polymorphonuclears. No organisms were seen on direct smear but culture grow the B proteus.

The spinal fluid sugar was too low to be measured. The total protein in the spinal fluid was 600

The urine on admission was cloudy yellow and had a specific gravity of 1 015. It contained 4 pig. albumin 4 plus glucose 4 plus acetone and 10

leukocytes per high power field

The patient was given penicillin intrathecally and intramuscularly as well as sodium sulfadiazine intra venously She received Insulin, and on the second hospital day the urine showed I plus glucose and a trace of acctone. The blood sugar was 173 mg per 100 cc.

The temperature on the second hospital day hov ered between 100 and 101 F The therapy previously described was continued The blood sulfonamide level was reported as 11.8 mg. per 100 cc Another spinal tap revealed the same type of fluid the total protein was 228 mg per 100 cc. the sugar was too low to be determined, and B proteus again was grown in pure culture. Bacillus proteus was recovered from culture of the discharge of the left car Blood culture was negative A bed-side x ray showed areas of rarefaction of the mastoid on the left side.

Streptomyem was given intrathecally in 100,000 units at the end of the second hospital day and 100,000 units intramuscularly for three doses

Mastoldectomy was contemplated but postponed because of the patient's poor condition. She failed rapidly despite the chemotherap; and supportive treatment and died on the morning of the third hospital day

It was the impression of the neurologist that involvement of the left oculomotor and facial nerves indicated that infectious process had spread to the

petrous portion of the temporal bone

Postmortem examination revealed thick turbid fluid in the subarachnoid space over the surface of the hemispheres, particularly marked over the fron-tal and occupital lobes. The posterior fossa of the skull contained a large quantity of thin brownish loul-amelling purulent fluid Pus drained through the left internal acoustic meature around the eighth Delva

The petrous portion of the left temporal bone was opened and the mastoid antrum exposed bony structure was necrotic and contained foul-

amelling pus.

Postmortem cultures taken from the posterior fossa and from the petrous portion of the temporal bone grew B proteus in pure culture This organham was gram-negative and motile grew in ir regular spreading colonies on agar liquefied golatin, split urea, produced H.S. and fermented dextrose and and sucrose, but failed to ferment lactose, mannite and maltose It, therefore is identified as the species Proteus mirabilis

Treatment of B proteus Meningitis

Since the advent of chemotherapy 6 cases of B proteus meningitus secondary to otitis media have been reported in the literature, our case being the seventh Of this total, three recovered and four died, the mortality rate being 57 1 per cent. All of these cases received sulfonamide medication. Our case received in addition penicillin and streptomy cin intramuscularly and intrathecally Surgical drainage was instituted in 0 of these cases and in the seventh (our case) surgery was not performed because of the poor condition of the patient.

Of the 15 cases reported prior to the advent of chemotherapy (7 of which were secondary to otitis media) there were two recoveries and thirteen deaths, a mortality rate of 86 7 per cent. One of the cases which recovered was that of a protous meningi

tis secondary to otitis media.

Despite the paucity of cases reported chemother apy appears to offer a definite improvement in prognosis.

Summary and Conclusion

- The 21 cases of Bacillus proteus meningitis reported in the literature are reviewed.
- 2. An additional case is reported, caused by Proteus mirabilis.
- Of all cases of B proteus meningitis, 62 per cent are secondary to otitis media.
- The case records suggest that chemotherapy is beneficial in the treatment. However no conclu sions can be drawn because of the paucity of cases thus far reported

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MEDICAL NEWS

State Health Head Outlines New Plan

PLANS for decentralizing the State Department of Health to make public health facilities more readily available to the people by operating on a basis of counties rather than the district system, were presented January 23 by Dr Herman E Hilleboe, State Commissioner of Health

Dr Hilleboe addressed the midwinter meeting of the Public Health Association of New York City

The first step in the reorganization will be to replace the 18 district health offices with six regional The regional offices were to be in operation by February 1, he said, and the district offices closed Regional offices are to be in Buffalo, Rochester, Syracuse, Albany, and New York New York will have two regional offices, Dr Hilleboe said, one to serve the surrounding counties and one to serve the

Under the six regional offices, county health offices are to be established in each of the fifty-seven counties, in addition to city health offices

"These regional offices will have for their principal

purpose the provision of consultation service to the staffs of the city and county health departments within their regions, assistance in program plan-ning, development, and operation," he continued "No district services will be given by any of the

personnel assigned to the regional offices, except to people in the counties that have not yet organized a

health department '

During the first year of operation of this system, Dr Hilleboe added, the State Department will concentrate on establishing county offices in seven to ten At the end of the year, he said, the whole State health situation will be re-evaluated and effort shifted to other counties

'It is our sincere hope that over a period of five years we can develop a county health department in every county which has the need and is willing and able to proceed," he said "Those remaining must be regrouped and receive services from neighboring county and city health departments, or temporarily from the State

Surgical Supplies for Europe Sought

R ALLEN O Whipple, professor emeritus of surgery at Columbia University, has been named chairman of a group to make a national appeal to doctors and hospitals for medical and surgical supplies needed in war-devastated areas, the Medical and Surgical Relief Committee announced recently The committee is seeking \$250,000 in direct gifts of supplies and money to carry on its work this year

The appointment of Dr Whipple, who is clinical director of Memorial Hospital, was disclosed by Admiral William F Halsey, president of the committee, which in the last seven years has shipped overseas more than \$1,000,000 worth of medical and

surgical supplies

Dr Whipple said that sixteen prominent medical men had agreed to serve with him on a Medical Advisory Council The council will help to form committees in the United States and ask all doctors, hospitals and pharmaceutical concerns to donate drugs, medical, surgical, and dental supplies and publications for shipment overseas

These materials will be sent to hospitals, physicians, and dispensaries that give free care to the needy

"Practically anything we can spare, they can use effectively to prevent suffering and death," Dr

Whipple explained

"They need all types of drugs, anesthetics, gauze, hospital ware, surgical instruments, penicillin, sulfa compounds, vitamins, and virtually everything which will help a doctor to serve his patients efficiently "

Another outstanding need is for recent medical and surgical textbooks and journals, he said, adding that "some doctors in war areas haven't even seen a medical journal or textbook printed since 1939, and are woefully uninformed of many of the latest medi-

cal advances "

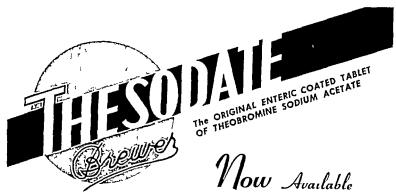
The New York City members of the council, who will assist Dr Whipple are Dr Henry Cave, attending surgeon of the Roosevelt Hospital, and Dr Carnes Weeks, attending surgeon of Bellevue Hospital

Miss Fillmore Appointed NOPHN General Director

A NNA Fillmore, of New York, has been appointed general director of the National Organization for Public Health Nursing to succeed Ruth Houlton, according to an announcement by Ruth W Hubbard, president of the organization

Miss Fillmore has been with the Visiting Nurse Service of New York since 1940, having served successively as staff nurse, supervisor, industrial nurs-

ing consultant, and assistant director
Prior to 1940, Miss Fillmore was director
of the Bureau of Public Health Nursing, Utah State Health Department, and also the assistant director of the American Nurses Association, New



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to meet the requirements and requests of many physicians

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MEDICAL NEWS

State Health Head Outlines New Plan

PLANS for decentralizing the State Department of Health to make public health facilities more readily available to the people by operating on a basis of counties rather than the district system, were presented January 23 by Dr Herman E Hilleboe, State Commissioner of Health

Dr Hilleboe addressed the midwinter meeting of the Public Health Association of New York City

The first step in the reorganization will be to replace the 18 district health offices with six regional The regional offices were to be in operation by February 1, he said, and the district offices closed Regional offices are to be in Buffalo, Rochester, Syracuse, Albany, and New York New York will have two regional offices, Dr Hilleboe said, one to serve the surrounding counties and one to serve the

Under the six regional offices, county health offices are to be established in each of the fifty-seven counties, in addition to city health offices

"These regional offices will have for their principal

purpose the provision of consultation service to the staffs of the city and county health departments within their regions, assistance in program plan ning, development, and operation," he continued. "No district services will be given by any of the

personnel assigned to the regional offices, except to people in the counties that have not yet organized a health department "

During the first year of operation of this system, Dr Hilleboe added, the State Department will con centrate on establishing county offices in seven to ten At the end of the year, he said, the whole State health situation will be re-evaluated and effort shifted to other counties

"It is our sincere hope that over a period of five years we can develop a county health department in every county which has the need and is willing and able to proceed," he said "Those remaining must be regrouped and receive services from neighboring county and city health departments, or temporank from the State"

Surgical Supplies for Europe Sought

R. ALLEN O Whipple, professor emeritus of surgery at Columbia University, has been named chairman of a group to make a national appeal to doctors and hospitals for medical and surgical supplies needed in war-devastated areas, the Medical and Surgical Relief Committee announced recently The committee is seeking \$250,000 in durect gifts of supplies and money to carry on its work this year

The appointment of Dr Whipple, who is clinical director of Memorial Hospital, was disclosed by Admiral William F Halsey, president of the committee, which in the last seven years has shipped overseas more than \$1,000,000 worth of medical and

surgical supplies
Dr Whipple said that sixteen prominent medical men had agreed to serve with him on a Medical Advisory Council The council will help to form committees in the United States and ask all doctors, hospitals and pharmaceutical concerns to donate drugs, medical, surgical, and dental supplies and publications for shipment overseas

These materials will be sent to hospitals, physi cians, and dispensaries that give free care to the needy

"Practically anything we can spare, they can use effectively to prevent suffering and death," Dr

Whipple explained "They need all types of drugs, anesthetics, gauze, hospital ware, surgical instruments, penicillin, sulfa compounds, vitamins, and virtually everything which will help a doctor to serve his patients efficiently "

Another outstanding need is for recent medical and surgical textbooks and journals, he said, adding that "some doctors in war areas haven't even seen a medical journal or textbook printed since 1939, and are woefully uninformed of many of the latest medi-

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[Continued from page 426]

Dr Hawley Heads National Plans

A NNOUNCEMENT has been made of the appointment of Dr Paul R Hawley, former chief medical director of the Veterans' Administration, as chief executive officer of the National Organization of Blue Cross Hospital Service Plans and Blue Shield Medical-Surgical Plans

Dr Hawley will take over his new post on April 1, 1948, with headquarters in Chicago He will direct the activities of the Blue Cross Commission of the American Hospital Association Coordinating Agency for the 91 approved nonprofit hospital service plans in the United States and Canada, and the 48 nonprofit medical-surgical prepayment plans included in the program.

In the New York area the affiliated Blue Cross and Blue Shields organizations are the Associated Hospital Service of New York and the United Medical

Service, Inc.

To Submit Program on Foster Care for Children

SEVEN-POINT program designed to establish a measure of protection for all children placed m foster homes will be submitted to the State Legislature this month by the Special Committee on Social Welfare and Relief, according to a recent announcement by Assemblyman Harold C Ostertag The program is part of a thoroughgoing revision of New York's public welfare system on which the Ostertag Committee has been engaged since 1945

The legislative proposal, Assemblyman Ostertag said, will correct inadequacies in existing law relating to foster care of children and will eliminate certain undesirable practices, such as fee-taking in connection with placements by unauthorized persons or agencies The proposal should further establish, for the first time in State history, an index of the number of children under seven now receiving care away from their own homes Under present laws, no records exist as to the number of children placed away from their own homes with the exception of those placed by authorized agencies or brought into court for adoption

Community Service Society Appoints Seven Psychiatrists

STEP toward enlargement and consolidation of A its psychiatric services has been announced by the Community Service Society of New York City

Anna Kempshall, director of family service, disclosed the appointment of seven psychiatric consultants, to work as part-time staff members giving direct consultation to professional workers in the ten CSS district offices

Dr Peter B Neubauer will head the new unit The consultants are Dr Viola Bernard, Dr Inge Bogner, Dr Richard W Burnett, Dr Paul M Faergeman, Dr Marcel Heiman, Dr Philip Weiss-man, and Dr Gertrude Werner

MEETINGS

PAST

Long Island Surgical Society, International College of Surgeons

Dr Charles Gordon Heyd, attending surgeon at the New York Post-Graduate Hospital, spoke on "Surgery of the Colon" at a meeting of the Long Island Surgical Society of the International College of Surgeons, held at the Long Beach Memorial Hospital on December 16, 1947

Long Island physicians and members of the staffs of Long Island Hospitals were invited to attend the

session

Albany Society for the Advancement of Psychosomatic Medicine

Parents of children who have received help from physicians in psychological problems were guests of the Albany Society for the Advancement of Psychosomatic Medicine at a symposium on "Psychosomatic Pediatrics" held January 17 in Albany

Dr Otto A Faust, director of the department of pediatrics, Albany Medical School, and Dr Marjorie F Murray, associate professor of pediatrics and consultant on psychological problems of childhood, were in charge of the meeting Speakers included Dr

Clinton P McCord, Albany, Dr Edith B Jackson, associate professor of pediatrics, Yale University, and Dr Geraldine Pederson-Krag, New York City

Receipt of an anonymous contribution of \$10,000, to establish a fund for research in psychosomatic pediatrics, was announced by Dr Faust at the meet-

Saranac Lake Medical Society

Dr Carl Muschenheim, associate professor of medicine, Cornell University, Medical College, spoke on "Pulmonary Manifestations and Complications of Cardiovascular Diseases" at a meeting of the Saranac Lake Medical Society on January 14 at the Saranac Laboratory

On January 29, Dr Frank W Cotui, associate professor of experimental surgery, New York University, College of Medicine, spoke on "Recent Advances in Protein Nutrition"

Mount Sinai Hospital

Five scientific papers were presented at the clinical conference held at Mount Smar Hospital January 19. with Dr Arthur S W Touroff acting as chairman

[Continued on page 4301



PHENO-BEPADOL

For mild sedation plus dietary supplementation in the B-Complex factors, Pheno-Bepadol IVC offers a welcome addition to the modern armamentar rum Its palarability and compara tive freedom from liability to side reactions make it particularly desir able in such functional digestive disturbances as neuroses, vomiting of pregnancy, nervous colitis, etc. Pheno-Benadol IVC assures ideal sedation in simple insomnias quieting nervous symptoms and al laying apprehensions while providing all the benefits of B-Complex dietary supplementation





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[Continued from page 428]

Speakers and their topics included Dr Ralph L Citron, "Recurrent Sublivation of the Cervical Spine," with discussion by Dr Robert K. Lippmann, Dr Max Ellenberg, "Intermittent Diabetes Precipitated by Recurrent Cholecystitis," discussion by Dr Herbert Pollack, Dr Abraham Kaplan, "Parasagittal Meningioma," discussion, Dr Ira Cohen, Dr Harry L Jaffe, "Coronary Occlusion," discussion, Dr Arthur M Master, and Dr R M Berne, "Case for Diagnosis," discussion, Dr I Snapper

New York City Public Health Association

Dr Bert R Boone, senior surgeon of the United States Public Health Service, discussed the work of the service in developing a program for control of heart disease at the midwinter meeting of the Public Health Association of New York City, January 22 in New York

Also speaking at the sessions were Martin Allen Pond, assistant professor of public health, Yale University, Dr Herman E Hilleboe, State Health Commissioner, Dr Harry S Mustard, New York City Health Commissioner, and Dr E H L Corwin, executive secretary of the committee on public health relations of the New York Academy of Medicine

Manhattan and Bronx Chapter, Long Island College of Medicine

Re-establishment of the Manhattan and Bronx Chapter of the Long Island College of Medicine was completed at a meeting of alumni held January 20 at the office of Dr Elias Rauch, New York City

Guest speaker was Dr A W Martin Marino, of Brooklyn, president of the Alumni Association Chapter officers elected are Dr Benjamin Jab-

Chapter officers elected are Dr Benjamin Jablons, president, Dr Nathan Magida, vice-president, Dr Rauch, secretary, and Dr Philip Kassen, treasurer

The next meeting will be held late in February

Brooklyn Urological Society

Dr Frank C Hamm was elected president of the Brooklyn Urological Society for 1948, at a meeting of the group held in January Serving with him are Dr Lawrence L Lavalle, vice-president, and Dr Harold B Hermann, secretary-treasurer

New York Academy of Medicine

Dr Edward J Stieglitz, Suburban Hospital, Washington, D.C., gave the fourth lecture to the laity of the 1947–1948 series at the New York Academy of Medicine, on January 22 His topic was "On Being Old Too Young"

American Social Hygiene Association

Dr Thomas Parran, United States Surgeon General, was the principal speaker at the regional conference on social hygiene of the American Social Hygiene Association, February 4, in New York City His topic was "Are We Stamping Out Syphilis?"

At the afternoon session on clinical and social aspects of venereal disease, Dr Harry S Mustard, New York City Health Commissioner, presided

Eastern New York Eye, Ear, Nose and Throat Association

Dr Fred W Dixon, assistant professor of otolaryngology at Western Reserve Medical College, Cleveland, Ohio, spoke on "Unusual Nasal Sinuses and Their Relationship to Ophthalmology and Otolaryngology" at the meeting of the Eastern New York Eye, Ear, Nose and Throat Association, on February 5 in Troy

Women's Medical Society of New York State

Plans for the annual meeting of the Women's Medical Society of New York State, which will be held at the Hotel Pennsylvania, New York City, May 16 and 17, were made at the midyear meeting of the group February 7 and 8, in New York

Dr Helen Walker, president of the Society, was in

charge of the councillor's meeting

FUTURE

John T Mather Memorial Hospital, Port Jefferson

A teaching day on kidney disease has been arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York for the staff of the John T Mather Memorial Hospital, Port Jefferson, on February 19, beginning at 11 30 A M.

Taking part in the program will be Dr Louis F Bishop, assistant professor of clinical medicine, New York University, College of Medicine, who will speak on "Hypertension and Hypertensive Renal Disease," Dr Edward Craig Coats, instructor in surgery, Cornell University, Medical College, "Suppurative and Calculous Diseases of the Kidneys," and Dr William Goldring, associate professor of medicine, New York University, College of Medicine, "The Clinical Aspects of Glomerulonephritis"

American Otorhinologic Society for the Advancement of Plastic and Reconstructive Surgery

The next regular meeting of the American Otorhinologic Society for the Advancement of Plastic and Reconstructive Surgery will be held at the County Medical Society Building, Philadelphia, Pennsylvania, on February 26 The session will begin at 8 P M

New York and Brooklyn Fracture Committee, American College of Surgeons

The thirteenth annual Fracture Day, sponsored by the New York and Brooklyn Fracture Committee of the American College of Surgeons, will be held February 28 at the Lenov Hill Hospital, New York City, with Dr Preston A Wade acting as chairman Dr Frank E Stinchfield is chairman of the committee for the program

Speakers at the morning session and their topics will include Dr Robert H Kennedy, "Mechanical Problems in Open Reductions", Drs Lester Breidenbach and Jere W Lord, Jr, "Management of Arterial Injuries Associated with Fractures and Dislocations", Dr Russell Patterson, "Thrombophlebitis Associated with Hip Fractures", Dr J Lawrence Pool, "Neurosurgical Aspects of Fracture

[Continued on page 432]



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Dual Sulfonamide Suspension

The efficacy and safety of sulfonamide therapy are greatly enhanced through the use of Aldiazol. This palatable liquid preparation provides a suspension of both microcrystalline sulfadiazine and sulfathiazole together with the alkalizing salts sodium citrate and sodium lactate.

Aldiazol leads to therapeutic sulfonamide blood levels more quickly than is possible with ordinary sulfonamides, since its sulfadiazine and sulfathlazole are in microcrystalline form

Recent studies* have shown that the combined unne solubility of two sulfonamides is greater than that of a single sulfonamide since the presence of one exerts little influence upon the solubility of the other. Consequently a greater total quantity of concurrently administered sulfadiazine and sulfathiazole can be dissolved in the unne than of either drug alone, resulting in a lowered incidence of crystalluria and its complications. The presence of alkalies in Aldiazol further reduces the denger of crystalluria. In addition the excreted sulfonamides are largely in non-conjugated form a valuable feature in the treatment of urnary infections.

Aldrazol is indicated in the treatment of many infectious diseases amenable to sulfonamide therapy Being a palatable liquid it is especially useful for children

"Lehr D.; Proc. Soc. Exper Biol. & Med. 58:11 (Jan.) 1945

Lehr D ; Slobody L., and Greenberg W : J Pediat. 29:275 (Sept.) 1946.



Each teaspoonful (5 cc.) contains
Sulfadiasine (microcrystalline) 0.25 Gm.
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Sodium Citrate 0.50 Gm. Sodium Lectate 0.60 Gm.

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[Continued from page 430]

Dislocation of the Cervical Spine", Dr Thomas W Stevenson, "Importance of a Well Nourished Skin Covering for Bones, Joints and Tendons", Dr David M Bosworth, "Posterior Fixation of the Fibula Behind the Tibia in Fractures of the Ankle Joint", Dr William H Cassebaum, "Postwar Experiences in Treatment of Compound Fractures with Use of Internal Fixation," and Dr Charles W Lester, "Recognition and Treatment of Lung Lacerations Secondary to Severe Thoracic Cage Damage."

At the afternoon session Dr William Darrach will introduce Mr H. Osmond-Clarke, London, England, who will give the Clay Ray Murray Memorial Lecture, by invitation Other speakers will be Drs Henry Jordan and Walter Galland, "Treatment of Fractures by Means of Roger Anderson Pm Fixation," Dr Harrison McLaughlin, "Treatment of Long Bone Fractures by Open Reduction," and Dr Edward Winant, "Treatment of Long Bone Fractures by Means of Traction"

Cornell University Medical College

The fifteeth anniversary of the Cornell University Medical College is being celebrated this year, and on March 11 a special Alumni Day program will be held at the College

Included on the program will be registration, luncheon at the Nurses Residence, a business meeting, and conferences in all departments. A dinner dance at the Roosevelt Hotel will conclude the day's program

Long Island College of Medicine

Its fifth postgraduate course in industrial medicine will be presented by the Long Island College of Medicine during the two-week period from April 5 to April 16, under the auspices of the department of preventive medicine and community health

Main objective of the course is to provide physi-

cians engaged in full or part time industrial practice an opportunity to become acquainted with the most recent developments in the field of industrial medi-

Morning demonstrations and afternoon seminars will be held at the College and in representative industrial plants each day during the two weeks, and will cover such topics as "Health Services for Industrial Workers," "Occupational Health," "The Industrial Physician and Health Insurance," "Management of Medical and Surgical Emergencies in Industry," "Rehabilitation of the Injured Worker," "Occupational Diseases," "Respiratory Infections in Industry," and "Surgical Problems of Importance to the Industrial Physician"

Tuition for the entire course will be \$75 Inquiries should be addressed to Dr Thomas D Dublin, Department of Preventive Medicine and Community Health, 248 Baltic Street, Brooklyn 2,

New York

American Academy of Pediatrics

The area meeting of the American Academy of Pediatrics will be held at the Statler Hotel, Buffalo, from April 29 to May 2 Members of state medical societies are invited to attend

Advance registration may be made by writing to Dr C G Grulee, secretary-treasurer, American Academy of Pediatrics, 636 Church Street, Evanston, Illinois, enclosing a check for \$10 for registration fee and banquet, or registration may be made at the time of the meeting

American Dietetic Association

The 31st annual convention of the American Dietetic Association will be held in Boston, Massachusetts, from October 18 through October 22, it has been announced

Meetings in connection with the convention will be held in the Hotel Statler, and exhibition space has been arranged for in Mechanics Hall

PERSONALITIES

Honored

Dr S Edward King, chief of medical service at Halloran Veterans Administration Hospital, Staten Island, recently decorated with the Bronze Star Medal for services in 1944 in the European Theater, entered military service in 1942 and was discharged in 1947 with rank of colonel, served as chief of medical service at various hospitals in ETO, including the 117th, 103rd, and the 300th general hospitals, while in Mediterranean theater, received Army Commendation Ribbon and Order of Knight Officer, Crown of Italy

Appointed

Dr William A Brumfield, Jr, Delmar, director of the New York State Department of Health division of venereal diseases, as deputy State Commissioner of Health, effective January 1 Dr Henry W Cave, New York City, as a vice-chairman of the men's committee of the 1948 Salvation Army appeal

Dr Alvah R Davignon, Loudonville, as a member of the three-man medical board of the State Employes' Retirement System Colonel John A Evans, physician and radiologist at New York Hospital, assigned to 377th Evacuation Hospital, Organized Army Reserve, the Bronx.

Colonel Robert T Findley, New York City, assigned to 320th General Hospital, Organized Army Reserve, New York City Colonel Theodore Golden, New York City, assigned to 333rd General Hospital Organized Army Reserve, New York City

Hospital, Organized Army Reserve, New York City Colonel Benjamin Lubitz, New York City, assigned to 445th Ship's Complement, Organized

Army Reserve, Brooklyn

Colonel Robert D McKay, Brooklyn, assigned to 376th Evacuation Hospital, Organized Army Reserve, Brooklyn Colonel Abraham Norman, chief medical officer, Veterans Administration regional office, Brooklyn, assigned to 334th General Hospital, Organized Army Reserve, Jamaica.

Dr Berwyn F Mattison, director of the Yonkers

Dr Berwyn F Mattison, director of the Yonkers Tuberculosis and Health Association, as first Erie County health commissioner, for a term of six years, beginning January 1 Dr A J Zaia, Oneida City Hospital, former president of the Madison County Medical Society, as a member of the Oneida Board of Health

Elected

Dr James D Tyner, president of the Newark Doctors Association, succeeding Dr Evan Tansley [Continued on page 434]



Loss of vibration sense is one of the most characteristic signs of spinal cord involvement in pernicious anemia. This is a serious complication because it may cripple and disable the patient Early diagnosis of pernicious anemia and intensive, continuous treatment are important factors in preventing spinal cord sclerosis

In administering such vital therapy it is important to make certain that the preparation you employ or prescribe is reliable potent and effective Eminent authorities have pointed out that the use of substandard liver preparations is one of the chief causes of failure in permicious anemia therapy

In the processing of ARMOUR LIVER PREPARATIONS every precaution is taken to preserve the blood regenerating active constituents of fresh liver. The ARMOUR LABORATORIES has been a pioneer in the preparation of therapeutic liver extracts and Armour technicians and scientists are experienced in the processing of the best in animal products.



Armour Liver Preparations

Liver Liquid Parentera)

4 U.S P Injectable units per cc.
1 cc. 5 cc., and 10 cc. rubber-capped vials

10 U.S.P Injectable units per ce.—1 cc., 5 cc., and 10 cc rubber-capped vials

15 USP Injectable units per co.—1 co., 5 cc., and 10 cc. rubber capped vials

Solution Liver Extract—Oral 45 cc. equal 1 U S P Oral Unit

Uver Extract Concentrate Capsules

9 capsules equal 1 U.S.P. Oral Unit Boxes of 50 and 100

Have confidence in the preparation you prescribe or administer — specify "ARMOUR"

THE ALMOUT LABORATORIES

[Continued from page 432]

also elected were Dr Jacob Cohen, vice-president, and Dr Joseph J Kaufman, secretary

Speakers

Dr Arthur J Bedell, Albany, at the Pan-American Congress of Ophthalmology in Havana, Cuba, January 8, where he read a paper on "Hypertensive Fundus" Dr Bedell was recently named a member of the Cuban Society of Ophthalmology Dr Herman E Hilleboe, New York State Health Commissioner, one of the lecturers in the series presented

by the George Washington University School of Medicine, Washington, D C

New Offices

Dr Melvin Harbater, New York City, who served more than five years in the Army Medical Corps, practice of ophthalmology in Utica. Dr Wilbur J Manley, former captain in Army Medical Corps, practice of internal medicine in Olean Dr Selden T Williams, Jr, formerly of Warsaw, New York, now in general practice in Attica

COUNTY NEWS

Albany County

Dr Robert R Linton, associate in surgery, Harvard Medical School, was the guest speaker at the meeting of the Albany County Medical Society January 28 at the Albany College of Pharmacy His topic was "The Surgical Treatment of Hypertension."

New officers of the group are Dr John J Clemmer, president, Dr Edward S Goodwin, vice-president, Dr Albert Vander Veer, 2nd, secretary, Dr Frances E Vosburgh, treasurer, and Drs Raymond F Kircher, Claude C Nuckols, and Christopher Stahler, delegates New members elected include Drs John K. Meneely, Jr, Ray E Trussell, James B Roberts, Irving Gordon, Daniel E Lester, and John C O'Keeffe

Allegany County

On the recommendation of the Allegany County Medical Society, Dr Dorothy Gray, Belfast, was appointed by the board of supervisors as a member of the County Bacteriological Laboratory Board

Broome County

Dr J C Zillhardt, chief of staff of Charles S Wilson Memorial Hospital, Johnson City, was reelected president of the Broome County Medical Society at the annual meeting December 9 in Bingbamton

Dr William B Aten, chairman of the rheumatic fever committee of the Broome County Medical Society, discussed community services available for rheumatic fever victims at a staff meeting of the Binghamton Health Bureau's public health nurses in December

Establishment of a cancer information center in connection with the new cancer prevention and detection program of the Broome County Tuberculosis and Public Health Association has been announced. The center will be located in Binghamton

Chautauqua County

Dr Everett O Black, Fredonia, was elected president of the Chautauqua County Medical Society at its annual meeting in Jamestown Other officers are Dr William L King, Jamestown, first vice-president; Dr Samuel Patti, Dunkirk, second vice-president, Dr Edgar Bieber, Dunkirk, secretary, and Dr C E Hallenbeck, Dunkirk, treasurer

Guest speaker at the meeting was Dr Leslie H Backus, Buffalo, who discussed plastic and reconstructive surgery

Chenango County

Dr John H Hollis, Norwich, was re-elected president of the Chanango County Medical Society at the annual meeting December 14 in Norwich Other officers named are Dr Newton Brachin, Greene, vice-president, Dr John Stewart, Norwich, secretary-treasurer, and Dr J Mott Crumb, South Otsehc, delegate

Dr Robert Karns, assistant director of the State Department of Health, spoke on the problem of poliomyelitis, and led a group discussion. Another guest speaker was Dr Robert Hannon, executive officer of the State Medical Society, who discussed medical legislation.

Cortland County

New officers for the Cortland County Medical Society, elected at the annual meeting December 19 in Cortland, are Dr Robert Henry Kerr, president, Dr Warren J Pashley, vice-president, Dr Edward F Higgins, secretary, and Dr Frank F Sornberger, treasurer

Delaware County

Members of the Delaware County Medical Society have voiced unanimous disapproval of the proposed county hospital and health plan which has been approved by the board of supervisors following a report of the State Department of Health recommending the plan

Suggested by the Hospital Survey and Planning Commission of New York State, the plan recommends a \$503,000 county hospital expansion program at Sidney, Delhi, and Hancock, and the establishment of a county health department and labo-

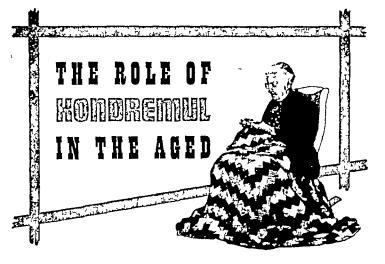
ratory with headquarters at Sidney

The County Medical Society voted to petition the board of supervisors to reject the plan as not workable for the county, arguing that in a centralized hospital patients would be beyond reach of their families, and that their regular physicians would be unable to give them any regular care, thus burdening local physicians The County Society plans to offer alternate recommendations to the county as soon as possible

Fulton County

Dr Malcolm McMartin, Johnstown, was elected president of the Fulton County Medical Society at its annual meeting December 18 in Gloversville, succeeding Dr Francis Hyland, Gloversville

[Continued on page 436]



Constipation has long been one of the more frequent disorders accompanying old age, due to definite structural changes and a general slowing up of all the physiological functions

As a result of these changes the physician often finds it neces sary to prescribe some medication that will help establish regularity

KONDREMUL

(An Emulsion of Mineral Oil and Irish Moss)

—as the regulator of choice—is pleasant to take, creamy in consistency and satisfies the most fastidious

KONDREMUL Plain (containing 55% mineral oil)

KONDREMUL with non bitter Extract of Cascara (4 42 Gm per 100 cc.)

KONDREMUL with Phenolphthalein—13 Gm (2 2 grs) phenolphthalein per tablespoonful.

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[Continued from page 434]

Other officers elected are Dr Herbert Hageman, Gloversville, vice-president, Dr William Raymond, Johnstown, treasurer, and Dr Robert Lenz, Gloversville, secretary

Genesee County

A new basic fee schedule, effective January 1, has been adopted by four Le Roy physicians, after due consideration of increased costs, it has been announced A similar proposal to establish rates for other communities was discussed at a recent meeting of the Genesee County Medical Society, but no action taken

Minimum charges announced are office visits, \$2 50, house visits from 7 AM to 7 PM, \$3 50, 7 PM to midnight, \$4 50, and midnight to 7 AM,

\$5 50

Jefferson County

Dr Gray H Twombly, assistant professor of cancer research, Columbia University, College of Physicians and Surgeons, spoke to members of the Jefferson County Medical Society at their meeting February 12 in Watertown His topic was "Recognition and Treatment of Pelvic Cancer," and the program was postgraduate instruction arranged by the State Society Council Committee on Public Health and Education

Kings County

Louis I Dublin, Ph D, statistician for the Metropolitan Life Insurance Company of New York, spoke on "Longevity and Mortality of American Physicians 1938–1942" at the meeting of the Kings County Medical Society January 20 at the Medical Society Building

Society Building
Dr A. W Martin Marino, new president of the group, gave his maugural address, 'Pro Bono Pub-

lico," at this meeting

Topic for the February 17 meeting is "Medicine at the Crossroads" and will be discussed by Captain R Harold Draeger of the Medical Corps of the U.S. Navy Former executive officer of the Naval Medical Research Institute, Captain Draeger was selected to direct the medical and biologic research at Bikini during the atom bomb tests

Montgomery County

Dr Raymond E Wytrwal, St Johnsville, was elected president of the Montgomery County Medical Society at the annual meeting in December

Other officers named are Dr R R Violyn, Amsterdam, vice-president, Dr David W Childs, secretary, and Dr Fred F Pipito, Amsterdam, treasurer

surer

Niagara County

A paper on "Pulmonary Embolism" was presented by Dr John Ambrusko, North Tonawanda, at the meeting of the Niagara County Medical Society on January 13 in Lockport Dr W W Pierce, Lockport, newly elected president, was chairman

The Society voted a donation of \$500 to the National Physicians' Committee to assist in the fight against compulsory health insurance. The members were urged to continue their individual contri-

butions.

Orange County

Dr Theodore R Proper, Newburgh, was elected president of the Orange County Medical Society at a meeting attended by 146 members December 10 in Middletown Other officers elected for 1948 were Dr Arnold Messing, vice-president, Dr E C Waterbury, secretary-treasurer, and Drs M A Stivers and W W Davis, delegates to the State Society

Otsego County

Elected president of the Otsego County Medical Society, succeeding Dr Charles B Kieler, Cooperstown, is Dr Edward J Keegan, Oneonta New vice-president of the Society is Dr John W Latcher, Oneonta, and secretary-treasurer is Dr John M Constantine, Oneonta

Richmond County

Topics and speakers for the March Friday afternoon sessions of postgraduate instruction, arranged for the Richmond County Medical Society by the State Society in cooperation with the State Department of Health, will be

ment of Health, will be
March 5—"The Management of the Failing
Heart," Dr Harry Gold, professor of clinical pharmacology, Cornell University Medical College

March 12—"Gastromtestinal Hemorrhage," Dr Albert F R Andresen, professor of clinical medi-

cine, Long Island College of Medicine

March 19—"The Treatment of Burns and Hand Infections," Dr David Goldblatt, associate clinical professor of surgery, New York Post-Graduate Medical School

March 26—"Cancer of the Stomach," Dr George T Pack, assistant professor of clinical surgery, Cor-

nell University Medical College

The lectures begin at 4 30 P M, and are held in the auditorium of the United States Marine Hospital, Stapleton, Staten Island

Schenectady County

"The Use of Cell Smears in the Early Diagnosis of Cancer" will be the topic of a lecture in postgraduate instruction to be presented by Dr George N Papanicolaou, professor of clinical anatomy, Cornell University, Medical College, at the meeting of the Schenectady County Medical Society April 6 at the Ellis Hospital, Schenectady

Sullivan County

Dr Frederick N Marty, assistant professor of clinical medicine, Syracuse University College of Medicine, will speak on "Plasma Therapy and Whole Blood Transfusion" at the meeting of the Sullivan County Medical Society February 25 in Liberty

The program is postgraduate instruction arranged by the Council Committee on Public Health and

Education of the State Society

Westchester County

"The Present Status of Vagotomy in the Treatment of Peptic Ulcer" was discussed by Dr Julian M Ruffin, associate professor of medicine, Duke University, at the meeting of the Westchester County Medical Society January 20 in White Plains

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HOSPITAL NEWS

Alcoholic Center Urged for State

PROPOSAL that the State accept responsibility A for treating and rehabilitating alcoholics and establish an experimental hospital of not more than fifty beds for their care was made in January by the Westchester Joint Committee on Alcoholism

The joint committee, comprised of medical, civic, and religious leaders, recommended that the "pilot" hospital should be established near a heavily populated area where the incidence of alcoholism is high The proposal was made to the subcommittee on the problems of alcohol of the New York State Interdepartmental Health Council in Albany

Dr I Jay Brightman, chairman of the subcommittee on the problems of alcohol, said in Albany that his group would "take the Westchester report under serious consideration"

Dr Brightman said the subcommittee would give to the Health Council a plan for introduction into the Legislature

The Westchester committee said in its proposals that an estimated 6 6 per cent of adult males and 16 per cent of adult females are chronic alcoholics Nevertheless, the committee said, present knowledge of treating alcoholics is so limited, it would be preferable to start on a modest scale and add to it as knowledge advanced

The committee proposals, making a plea for considering alcoholics as ill persons rather than as criminals, recommended that the State social hygiene law be amended to provide for the certification of alco-

holics to public mental institutions

The Westchester committee, whose chairman is
Paul R Brown, warden of the Westchester County
Pemtentiary at East View, was started a year ago by
the White Plans Rotary Club It includes the Westchester Medical Society, the Mental Hygiene Association of Westchester County, the Salvation Army, and Alcoholics Anonymous

General Hospital Beds Planned for Madison County

MADISON County needs at least 130 new general hospital beds—70 of them in or near Hamilton—according to official New York State statistics released recently

These figures were received by Dr William Liddle, chairman of the Public Health Committee of the Board of Supervisors as part of the long-awaited survey by the New York State Department of Health and the Joint Hospital Survey and Planning Com-mission requested by supervisors Additional hospital beds for Madison County was

only one aspect of the over-all health needs of the county dealt with in the survey, which included recommendations concerning a county laboratory and public health department. In discussing the need for hospital beds, however, State officials stated In discussing the

"It is believed that the 130 additional general hos-pital beds for Madison County can be obtained best by adding 60 beds to the existing 80 beds at the Oneida City Hospital, providing a total of 140 beds in the city of Oneida, and by the construction of a new general hospital of 70 beds in the vicinity of Hamilton Village

"The Hamilton community, in the southern part of the county, is a logical place in which to locate general hospital facilities to serve the central and southern sections of the county and the borders of adjacent counties"

Bronx Hospital Admits General Practitioners

PLAN to provide hospital affiliation for quali-A fied general practitioners, who now are largely excluded from hospital staffs, was announced recently by the Bronx Hospital, the Bronx, through its director, Dr Aaron A Karan

Under the plan Bronx Hospital will add to its staffs a general-practice section, the first of its kind m any voluntary hospital in New York Most hospitals in New York are staffed entirely

by specialists
"Bronx Hospital is glad to pioneer this effort in
New York," Dr Karan said "There are approximately 2,100 physicians in Bronx County, of whom 1,600 are members of the County Medical Society Well over half of these have no hospital affiliation in the borough and cannot obtain hospitalization for

their patients except in proprietary institutions"
In the past, Dr Karan explained, voluntary hospitals have excluded general practitioners from their staffs, and it was necessary for these doctors to take their patients to more expensive private hospitals. Only doctors who are members of hospital staffs are allowed to use the hospitals' facilities, thus making it almost impossible for a general practitioner to treat a patient in a voluntary, nonprofit institution, where costs are less than at private hospitals



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Listed by the Committee on American Health Resorts of the American Medical Association [Continued from page 438]

NEWS NOTES

A clinic for peripheral vascular diseases has been opened by the Hospital for Joint Diseases, New York City, according to an announcement by Janice Seligman, supervisor of the outpatient department The clinic, which meets Monday and Friday mornings from 9 to 11 a m, is headed by Dr Isador Mufson

Dr John Pastore, executive director of the Hospital Council of Greater New York, spoke at an open meeting of the Health Council Division of the Brooklyn Council for Social Planning on February 5 topic was "The Master Hospital Plan as It Affects Brooklyn" The meeting was held at the Brooklyn Bureau of Social Services

Dr Thurman Boyd Givan, director of pediatrics at Cumberland Hospital, associate professor of pediatrics at Long Island College Hospital, and senior pediatrician at Norwegian Hospital, Brooklyn, was guest speaker at the February 18 meeting of the staff of Doctor's Hospital in Queens subject was "Prophylactic Measures in Pediatrics"

Dr George R Stuart and Dr Raymond P Sullivan, retiring as directors of the first and second surgical divisions, respectively, and Dr Stanley Brady, retired director of pediatrics, all of St Vincent's Hospital, New York City, recently received gold medals and illuminated scrolls from Francis Cardinal Spellman at a testimonial dinner

Dr Stuart has been associated with the hospital since 1908, Dr Sullivan since 1909, and Dr Brady smce 1926 All are continuing as members of the

senior consulting staff of the hospital

Expansion of the program to develop specialists, in line with a trend evident throughout the nation, is under way at the Syracuse Medical Center, according to a recent announcement by Dr H G Weiskotten, dean of the College of Medicine at Syracuse University

Dr Weiskotten pointed out that there are twentyfour doctors serving as assistant residents at the medical center and nine more as full-fledged resi-

dents in various categories of medicine, including surgery, internal medicine, obstetrics, gynecology, and pediatrics

As an example of the trend toward specialization, he cited the fact that the department of internal medicine has had more than 100 applications for

the four residencies it provides

However, the College of Medicine, while in stride with specialization, has taken cognizance of the need for better prepared general practitioners, and next July, Dean Weiskotten said, will initiate four residencies in general practice

Plans for improvements to Cohoes Hospital and a closer affiliation of the staffs with officials of the institute were discussed at the December meeting of the executive committee and the medical staff Dr A J Vinci, president, and Dr Francis M Noonan, vice-president of the medical staff, attended the conference

The regular clinical conference of Hillside Hospital, Queens, was held at the hospital on February The program was on "Contrasting Mechanisms in Two Patients with Obsessive Compulsive Neurosis," and was given by Dr Hans Kleinschmidt and Dr Gabriel de la Vega

The first Samuel Strausberg Memorial Lecture of the Beth-El Hospital, Brooklyn, was delivered by Dr William Goldring, associate professor of medicme at the New York University, College of Medicine, on February 18, at the Kings County Medical Society Building

Dr Goldring's topic was "The Present Status of Medical and Surgical Treatment of Hypertension" The lecture was in memory of Mr Strausberg, recently deceased, who was president of the hospital

from 1941 to 1946

The Isidore Friesner Lecture of the Mount Sinai Hospital, New York City, was given on February 2. by Dr José Trueta His subject was "The Renal Circulation"

PERSONALITIES

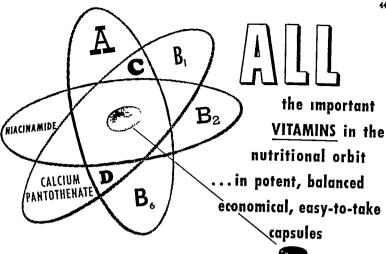
Appointed —Dr Ward L Oliver, Cobleskill, as a member of the Albany Regional Hospital Planning Council To the position of adjunct attending

physician on the medical service of Staten Island
Hospital, Richmond County, Dr Theodore Talbot
Dr Henry Briggin, formerly assistant surgeon, to
associate orthopedic surgeon, St Vincent's Hospital,
Richmond County Dr Herbert C Fett, who
interned at the Long Island College Hospital from 1913 to 1915 and joined the staff as orthopedic surgeon in 1917, as head of the orthopedic department

Elected —As vice-president of the National Committee of Mental Hygiene, Dr William L Russell, consulting psychiatrist at the New York Hospital As directors of the board of St James Mercy Hospital, Hornell, Dr Otto K. Stewart and Dr J Raymond Kell

Dr Morris Eber, Maine, as president of the Endicott Ideal Hospital's staff, succeeding Dr Roger D As vice-president and secretary of the Ideal Hospital staff, Dr John M Mallory and

Dr Michael J Maggiore



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CORRESPONDENCE

The Hysteric in General Practice

To the Editor

I wish to comment on the very informative editorial you published in the New York State Journal of Medicine of November 1, 1947, under the title, "The Hysteric in General Practice" In this editorial you discussed an article by the same name written by an English physician, Dr Wilfred Lester, which appeared in the British medical journal, The Practitioner

All praise to Dr Lester for his painstaking piece of work. I feel sure that Dr Lester would agree that his article shows what a "mere doctor without special psychiatric training can do" But I wonder what he would think of your final sentence "If he were practicing under socialized medicine he

could not even try"

I feel sure that he would be shocked if not disgusted, because he himself practices in Great Britain where a form of what you choose to call "socialized medicine" has been in effect for some thirty-five years! Apparently the panel system of Great Britain has not in any way interfered with Dr Lester's ability to cope with an hysterical woman And if, as you say, Dr Lester is a general practitioner without special psychiatric training, the chances are that he himself is participating in that very panel system

So, as I say, your editorial comment was very informative, but not in the way you envisioned. It shows to what extremes the American medical profession is willing to go to blind itself to facts, even to

the point of making itself ludicrous in the eyes of the American and British medical practitioners in order to prevent compulsory health insurance in this country

I wonder how long the doctors of this country will be content to let this distorted type of nonsense

appear in their official medical journals

(Signed) MARTHA MENDELL, M D 201 West 16th Street New York, New York

November 17, 1947

We publish Dr Mendell's comment on our editorial (New York State J Med. 47 2280, Nov 1, 1947) since we think it may represent the opinion of a few others of the medical profession, who find in "socialized medicine" no bar to the maintenance of quality in medical practice. In this particular instance, however, we would call the writer's attention to the illuminating book by Dr. A. J. Cronin, The Citadel. It may change her point of view as to the "benefits" associated with the English Panel System of practice. We do not seem to remember that these benefits included the leisure necessary to make detailed study of individual cases. On the contrary, the system as described by Dr. Cronin seemed to promote the pill and bottle type of practice of which "The Hysteric in General Practice" is the exact opposite, being a most painstaking study—The Editors.

NECROLOGY

[Continued from page 442]

the town of Cornwall He had been radiologist at Cornwall Hospital since 1931 He was a past president of the Orange County Medical Society and a member of the American Medical Association and the New York State Medical Society Dr Thompson was graduated from the New York Homeo-

pathic Medical College in 1908

Paul Henry von Zierolshofen, M D, of Croghan, died on January 20 He was eighty-four years of age In 1887 he was graduated from the New York University College of Medicine He had practiced medicine in Lewis County for sixty-one years and was health officer for the Town of New Bremen and the Village of Croghan He was on the staff of the St Lawrence State Hospital in Ogdensburg and the Lewis County Hospital in Lowville Dr von Zierolshofen was a member of the Military Surgeons of the United States, the American Medical Association, and the New York State and Lewis County medical societies

George Barclay Wallace, MD, of New York City, died on January 15 at the age of seventy-three Professor emeritus of pharmacology at New York University, Dr Wallace was senior member of the faculty at the University's College of Medicine, prior to his retirement in September, 1946, and chairman of the department of pharmacology, which he organized He had been associated with Bellevue Hospital since joining the college faculty in 1902 He was also consulting physician for Harlem Hospital, New York City He received his medical degree from the University of Michigan in 1897

Dr Wallace conducted extensive research on the biologic effects of alcohol, caffein, and anesthetics Recently he had been engaged in the studies of

water metabolism

He helped organize several professional groups, including the Society of Experimental Biology and Medicine, the Harvey Society, and the American Society of Pharmacology and Experimental Therapeutics, serving as managing editor of the journal of the latter society. He was also a member of the American Medical Association, the New York State and County medical societies, the Academy of Medicine, and the American Society for Clinical Investigation.

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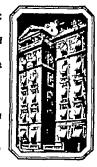
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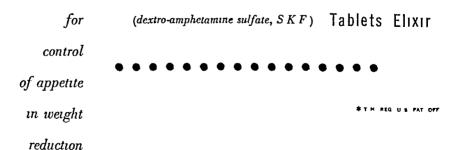
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NEW YORK STATE JOURNAL OF MEDICINE

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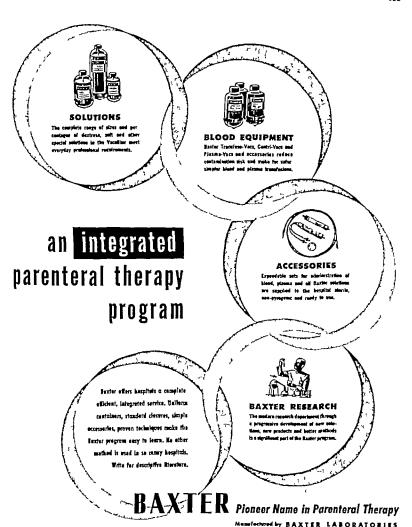
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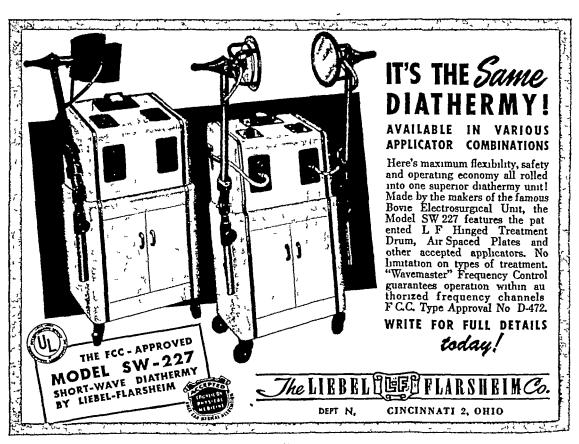
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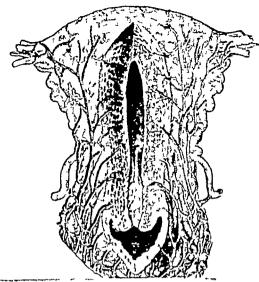
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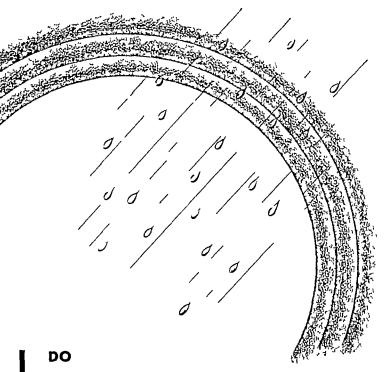
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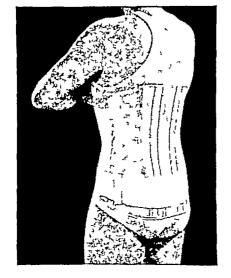


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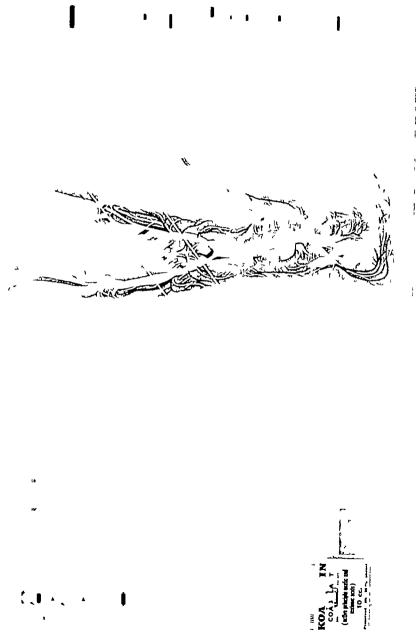
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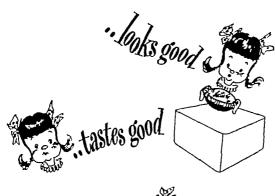
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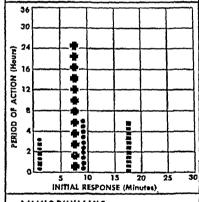


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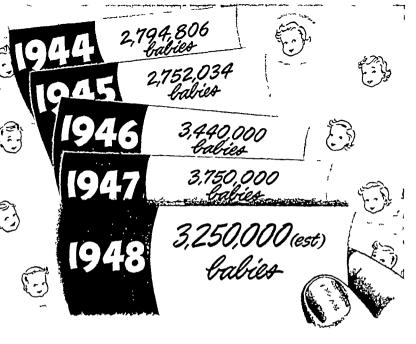
*Laryngoscope, Feb 1935, Vol XLV, No 2, 149-154, Laryngoscope, Jan 1937, Vol XLVII, No 1, 58-60, Proc Soc Exp Biol and Med., 1934, 32, 241; N Y State Journ Med., Vol. 35, 6-1-35, No. 11, 590-592



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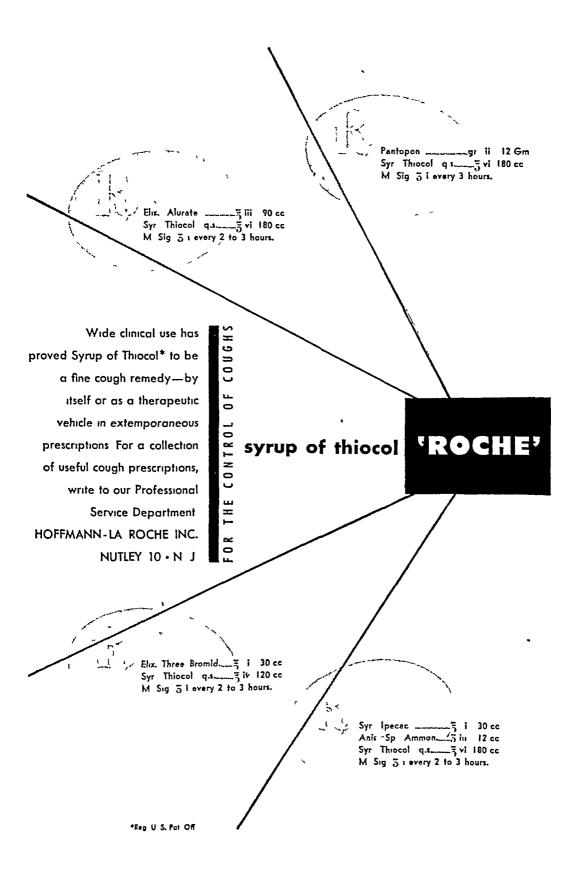
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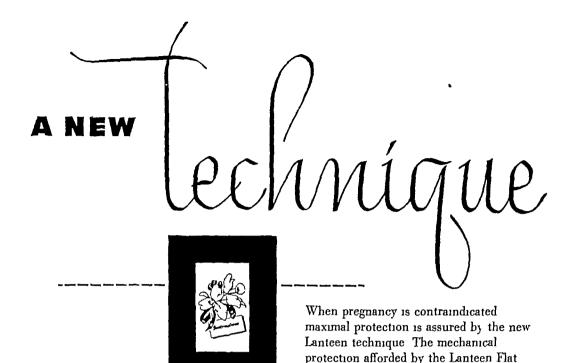
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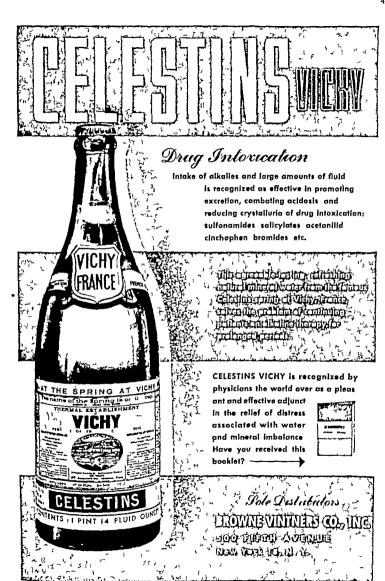
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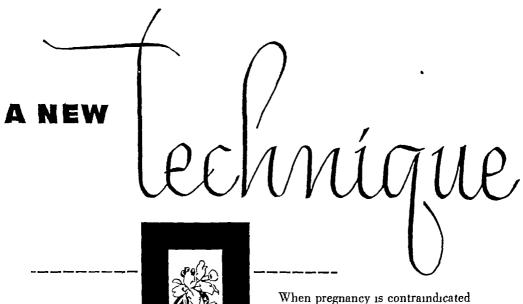
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Cooke, J. V : Brennemann Practice of Pedlatrica 4: Chap-MT 41 1945 31.2, Berson, R. A. et al. J Ped. 31: Oct., 1947

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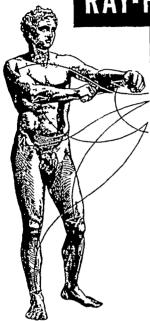
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- OUTLINE OF SUBJECTS FOR "TEACHING DAY"
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Editorials

The Annual Meeting

The JOURNAL again urges all who can to plan to attend the annual meeting to be held this year at the Hotel Pennsylvania, New York City, May 17 to 21 Reserve your hotel room now if you have not already done so, since accommodations are apt to be limited

Our readers will note that this year our April first number will be the Convention Issue To date the commercial exhibits will be the largest in number ever set up for a medical meeting at the Hotel Pennsylvania—132 exhibit booths occupied by some 116 firms all displaying the latest in pharmaceutic products and the most modern equipment manufactured for use in the field of medicine Large scientific exhibit sections will be set up for the first time at either end of the Hotel Pennsylvania's main ballroom, allowing by this arrangement a much more comprehensive scientific exhibit than has been possible in previous years.

The registration desk will be located, as in 1946, conveniently near the center of the meeting, assuring easy access to all points of activity. Our good friends, the exhibitors, who, year after busy year, cheerfully help to make possible our annual meetings by underwriting at least part of the cost, deserve your attention and patronage. They bring for your inspection and information the most recent developments in scientific apparatus, therapeutic modalities, the latest publications, and will cheerfully answer any and all questions about their products.

This year make it a point to come Watch for the Convention Issue of the JOURNAL, April 1, for announcements of the scientific programs, the proceedings of the House of Delegates, the annual reports of committees Plan now to attend, and above all, be sure to make your hotel reservations now, if you have not yet done so

The Chiropractic Bill

Like the traditional bad penny, the bill to license and legalize the practice of chiropractic in New York State has turned up again. Despite numerous unsuccessful attempts to throw a mantle of legality about their "profession," the chiropractors have marshalled their forces for another effort to achieve their objective This time, according to all indications, they intend to bring to bear more pressure than ever

On January 21, a bill was introduced in the legislature by Assemblyman L P Noonan, of Cattaraugus County, which would amend the education laws to provide for a State Board of Chiropractic Examiners whose function it would be to license chiropractors and to regulate their practice. As this is written, there is a prospect that the Noonan Bill may, be replaced or supplemented by another and that a companion bill will be introduced in the Senate. In any event, the principal aims will be the same

The stand of the medical profession on this controversial subject is clear. It holds that the basic theory of chiropractic is false, and in this it has the support of every scientific It maintains that, in dealing with human life and well-being, it is the duty of those men who have been given official authority by the State of New York to practice the healing arts to insist upon adequate standards of qualification Chiropractic 18 the practice of medicine, no matter what the chiropractors say about it The courts of the State of New York have ruled that it is If chiropractors practice medicine, they obviously do so without proper qualifications, because of the fallacy of their philosophy The licensing of an unqualified person does not change by one 10ta the fact that he remains unqualified

There are many more specific objections to the Noonan Bill, or its counterparts The bill would open the door wide to permit practically all present chiropractors to obtain a license without any examination The well-known "grandfather clause" does nothing to winnow the wheat from the chaff, but heenses anyone who has been "chiefly engaged" in the practice of chiropractic in the State for at least one year out of the past How many death warrants will this sign for credulous people with serious diseases who rely upon the "treatments" of correspondence school graduates? What of the betrayal of the trust of the unsuspecting patients to whom a license is an assurance of qualification?

The licensing of chiropractors would be a backward step in the steady progress of the healing arts The high standards set forth in the education law would suffer a severe blow To argue that chiropractors have gained a following among certain individuals and, consequently, ought to be licensed is poor logic Fortune tellers and astrologers flourish, yet no one seriously proposes to give them a license to operate fundamental question is adequacy of train-Let the chiropractors fulfill the requirements of the existing law in this respect, and no person will lift a finger to "discriminate" against them, as they often charge

With these and numerous other objections to the Noonan Bill to point to, the medical profession might rest confident in the assumption that the measure will never succeed. This would be a mistake Past failures on the part of the chiropractors to win legislative support for their bills give no assurance that the present bill will also fail. On the contrary, the present mood of the chiropractors is to bring about the adoption of the bill at all costs. Vigilance and aggressive action are necessary to ward off this threat.

To make their opposition to the bill effective, all physicians should make it their business to write directly to their legislative representatives expressing their views. Letters to the majority leaders of the Senate and Assembly and to the members of the Assembly Committee on Public Education, to which the bill was referred, also would help Assemblyman Wheeler Milmoe of Madison County is chairman of this committee. Letters should be written now. They may be addressed to the legislators either at the Senate or the Assembly Chamber, State Capitol, Albany, New York

This is a matter that cannot be left in the hands of a few people. The voice of the medical profession in all New York State must be raised in loud protest against such harmful legislation.

The chiropractors are flooding the mails with their side of the story. Every physician concerned with the future of his profession should join his fellows in doing the same

Current Editorial Comment

A Correction. In our November 15, 1947, issue¹ we referred editorially to an article published in the New York Times of July 27, 1947, which "reported, together with other matters, grants for scholarships in psychiatric fields recently made available by the National Mental Health Act and administered through the US Public Health Service." The quotation is from a letter received from Dr John Romano of Rochester, a member of the National Advisory Mental Health Council, an advisory body of six physicians who advise, consult with, and make recommendations to the Surgeon General on matters relating to the activities and functions of the US Public Health Service in the field of mental health

Dr Romano calls to our notice that in our editorial we unintentionally misrepresented facts, an act which we regret and hereby rectify Our editorial said that "Apparently the Surgeon General of the U.S Public Health Service proposes, according to the New York Times for July 27, 1947, to devote an appropriation of some \$4,650,000 to the further psychiatric training of social workers." This, as Dr Romano points out, is only part of the story as reported and signed by Murray Illson The complete report is reprinted herewith

Scholarships in Psychiatric Fields

With a grant from the National Mental Health Act, four competitive fellowships valued at \$9,600 will be awarded for the first time by the New York School of Social Work, Columbia University for postgraduate training in specialized psychiatric fields it became known yesterday

Carrying a total appropriation of \$4,650 000 the mental health measure recently adopted by Congress and approved by President Truman is designed primarily to help overcome the acute shortage of personnel in the various mental health specialty fields. The program calls for the establishment of training units in psychiatry, chalcal psychology, psychiatric nursing and psychiatric social work. It provides for grantsin-ald to states for establishing needed psychiatric services. Additional sums were appropriated also for psychiatric research.

Several social work schools throughout the country are to share an allocation of \$200,000 to reinforce the training units in psychiatric

social work under the new mental health plan it was learned. At the New York School of Social Work, which is a division of the Commun ity Seruce Society, two such training units will be established for second-year students attending the institution. There will be eight trainees in each unit

Additional Funds

To expand its psychiatric social work program in line with the aims of the National Mental Act, the New York school already has been granted a sum over \$25,000 Part of the allocation will go toward forming the two additional training units. The remainder will be used to finance the four competitive scholarships

According to Dr Walter W Pettit, dean of the school, the awards will carry a stipend of \$2.400 each and will cover an entire academic year beginning with the graduate school's winter quarter in January, 1948 The institution has set November 1 as the closing date for filing applications for the fellowships.

Candidates must be graduates of an accredited school of social work and must have had at least three years' practice in the profession. The post-graduate fellowship program, Dean Pettit disclosed, will consist of advanced courses in psychiatric social work and case work, combined with a specified number of hours to be given to specialized field work.

In addition to the Columbia University school, two other graduate institutions have received grants under the act for the fellowship courses. They are the Pennsylvania School of Social Work of the University of Pennsylvania and the School of Applied Sciences, University of Pittsburgh.

Nation-Wide Program

The training units to be started in the various graduate schools conform to a plan now being developed by the United States Public Health Service for a comprehensive nation wide mental health program under the recently enacted measure. The Public Health Service's Mental Hygiene Division, directed by Dr R. H. Felix, has been authorized by Congress to allocate the training funds to the several degree-granting institutions.

Terming the recent passage of the National Mental Health Act "most heartening," Dr Felix pointed out that the legislation 'gives us an opportunity to cope on a nation-wide scale with one of America's major public health problems—the seource of mental lilness."

¹ Editorial, "Our Coming Psychiatrists," p. 2408.

"The greatest current barrier to the development of mental health programs as a whole," he said, "is the lack of sufficient and well-trained personnel. It is futile, for example, to consider the establishment of clinics or the expansion of mental hospitals unless there will be trained personnel available to help staff them."

MURRAY LLISON

Male Hormone Therapy The increasing employment of these preparations, often in an indiscriminate fashion, should direct attention to a valuable presentation recently made by C W Dunn of Philadelphia, of which the following is a summary ¹

The clinical results obtained with testosterone therapy in all age groups of males and certain age groups of females indicate that the most valuable and desirable effects of testosterone are related to its action on the constitutional state A deficiency in the constitutional state is the basic and the primary defect existing in testosterone deficient patients All other features, subjective and objective, excluding the underdeveloped external genital state and the disturbance in endocrinous interrelationship present in the climacteric, are aftermath effects and/or are related to the degree of the testosterone deficiency which the in-dividual patient presents Even in these dividual patient presents patients, as the extreme degrees of the developmental effects are overcome, the continuance of therapy is based upon the maintenance of the constitutional state at a satis-Therefore, initially and fifactory level nally, we must evaluate the effect of testosterone preparations on the constitution of The value of testosterone to the patient the human must not be based upon its ability to develop the penis or to activate the waning or the disappeared sexual or psychosex-There are many other causes ual stimuli for sexual incapacity or absence of libido The use of testosterone to stimulate sexual activity in an otherwise normal individual is not advised, and if used, it will be found to be ineffective therapy

The administration of testosterone preparations should be restricted to patients exhibiting clinical and/or laboratory signs of testosterone or androgen deficiency. In patients with a testosterone deficiency it acts

as specific therapy only within the limits of its physiobiologic activity

It appears that underdeveloped testes will increase in size under certain circumstances, namely, youth, the presence of the anterior growth hormone, and the administration of testosterone preparations at a dosage level which only corrects the state of testosterone deficiency ¹

Leap Year The year 1948 is leap year This may have serious consequences for some young medical men who may be caught unaware by more alert designing females of the species. It seems only fair, and possibly our editorial duty, to sound a warning note to our young male readers to be on their guard against surprise proposals of marriage by the opposite sex. It's an old custom

These may come during the winter, when the young man's fancy is supposed to be hibernating and sluggish—a splendid opportunity for a surprise attack from ambush unless security is maintained at all times Recent military training can be a great asset to the young male Let him not forget the principles he has learned

Now as the year advances into spring and the male hibernating season comes to a close, the danger is greater. Then the young man's fancy turns to thoughts with which the predatory female has been toying all winter, and which the songwriters belabor ceaselessly as any one may verify, for who can escape the radio crooner or the juke-box moaners? It is all a well-planned campaign to undermine masculine defenses, whatever else it may be called

Ah, spring! That winter lingers in the lap of, ah, spring in leap year, divisible by four and dangerous to the unwary. Young men take warning! If you have come safely and unattached through January, watch yourselves in February. It's a short month, but don't count too much on that, look at the almanac, full moon on the twenty-fourth, 29 perilous days and the sap beginning to run in the sugar maples in an early spring thaw

This is merely a friendly word of warning. We don't expect it will do much good. But our sense of duty is strong, and we suspect that the human female may exert her customary leap year prerogatives as in the past—despite that new look.

¹ Dunn, C W Clinics 5 4 (1947)

Scientific Articles

COUNTY HEALTH DEPARTMENTS

EDWARD S GODFREY, JR M.D. Albany, New York

(From the New 1 ork State Department of Health)

THE year which has elapsed since the signing of Chapter 1000 of the Laws of 1946, amending the laws relating to the establishment of county health departments and State aid to counties for health work, has seen the most general interest of local officials in the development of county health departments since the original permissive act of While there may have been more discussion of the subject two decades ago this was so controversial in nature that political bodies and their leaders were loath to take action, and only six county health departments were established in twenty-five years.

By contrast, the past year has been marked by what may be called an eagerness on the part of political leaders and boards of supervisors to take advantage of the new law This has been abetted by the promise of federal aid for the construction of hospitals under Public Law 725 the so-called Hill Burton Act, and State aid to the larger cities and for tuberculosis.

The increase in State aid from a straight 50 per cent to 75 per cent for the first \$100,000 expended. while of relatively little importance to the larger and wealther counties, is a matter of moment to the vast majority It is estimated that the State will meet three-fourths of the total expenses needed for a competent health department in about 75 per cent of the counties a department meeting considerably higher standards than those proposed by the Subcommittee on Local Health Umts of the American Public Health Association

In many other counties the State's contribution will be three-fifths or more of the total, and these countles will be the ones to obtain additional State funds through rembursement for the hospital care of the tuberculous. For the most part, these patients have not been included in the areas served by the State tuberculosis hospitals, and while it is expected that the savings will be ad dressed primarily to intensified effort to eradicate tuberculosis, recognition should be given to better organized and intennfied local health service as being perhaps, the most effective instrument for that purpose.

Only 2 counties, Cattaraugus and Columbia suffer financially through these laws, and they had been treated with special favor in the past That is, they had been granted one-half the oper ating expenses of their tuberculosis hospitals in addition to one-half the cost of their county health departments

In addition to providing the larger grant of aid, Chapter 1000 sought to remove certain provisions of the county health department law which had been obstacles to the establishment of county health departments in the past. The most important of these provisions was the elimination of the mandatory abolition of health officers of towns and villages below 3 000 population, contained within a county health district.

This provision had been added to the law through an amendment passed in 1929, in answer to a complaint that such health officers burdened certain jurisdictions with taxes for their support, as well as for the county health department, and that they performed no commensurate service. It was the habit of the time to belittle the per formance of the part-time health officer in the attempt to obtain full time service, and there were enough "horrible examples" to lend cred ibility to the opinion.

The potentialities of the part-time health officers as obstructionists were entirely overlooked. however, and in my opinion their potentialities for useful service were not recognized were and are, too many of them, but this program was needlessly drastic. The present law is completely permissive The local political units are relieved of both the mandate to keep them and the mandate to let them go The decision is entirely with the smallest unit of government. It is home rule carried to the ultimate.

It seems to me there is an advantage in having a considerable number of on-the-spot practi tioners who have had a modicum of special train ing in public health work, who are alert to local health hazards, and who have a professional, as well as financial, interest in the health affairs of

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, Section on Public Health, Hygiene, and Sanitation, May 5, 1947

the community The development or maintenance of that alertness and professional interest is one of the affairs of the county health commissioners

Another impediment to (or perhaps "excuse for" would be better) the relegating of public health to smaller units of government has been conflict between rural and large city supervisors certain counties of the State, city supervisors equal or outnumber those from the towns, and it has been alleged that those from the city either frustrated the desire of town supervisors to form a county health district exclusive of the city or that they were bent upon throwing the cost of their city health work on the county as a whole The ostensible opinion of the town supervisors was that city health departments maintained certain services (diagnostic and treatment clinics, restaurant and food inspection, etc.) which were of little importance to the rural areas but added materially to the expense of operation

It is difficult to assess either the validity of these objections or the verity with which they reflect the real reasons for mertia. At any rate, it was recognized that, although a county health district might represent only that part of a county, exclusive of its contained cities, and although the costs were only levied on the tax units included in the district, the entire board of supervisors voted on the proposal and on the annual budget of the department

A further development of the home rule principle was therefore proposed and was adopted by the legislature. This permits the supervisors of that area of a county outside cities of 50,000 population to veto a county health district, including such cities, or to vote a district exclusive of such a city or cities. If the supervisors of such a city reject a proposal for such a part-county district voted by the outside supervisors, the city is penalized by becoming ineligible for State and

It remains to be seen how influential this factor has been. I am of the opinion that, for the most part, it has been a cover for partisan and factional rivalries, for fear of State domination, of increased taxes, of State failure to make good on its aid, of opposition from medical men, and possibly of other less tangible things. The fact that the three counties containing cities (one of them over 50,000) that have established county health departments this past year have included the entire county in their health districts seems to belie its importance. The more recent action of Eric County and the City of Buffalo is further evidence in this direction.

Along with the removal of obstructions there are several factors, contributing to increased interest and action, that deserve mention

There can be no doubt that high among these

in importance is the interest and strong leadership of Governor Dewey He virtually initiated the committee which reviewed the status of local health organization in the State and recommended the legislation which was later passed His administrative staff gave untiring assistance in drafting the bills, and his strong support assured their passage

I think it not improper to say that the fact that the Governor and the Legislature are of the same political party, and that this is the majority party in nearly all upstate counties, has certainly been a weighty factor in the improved attitude of boards of supervisors—It has given an assurance of State support which, heretofore, may have been felt to be somewhat doubtful

The State Department of Health has been, since my association with it, as clear of politics as any instrument of government can be Certainly, I encountered no political interference in appointments under the two governors responsible for my appointments as Commissioner

It will be understood, therefore, that I speak in no partisan sense when I make an acknowledgment I think due the party responsible for passing this outstanding advance in legislation and for making it effective. I would do the same for the opposing party if it had done and were doing the job

Backing this legislation, there had to be, of course, a considerable body of favorable public opinion. This has been ably fostered by the State Charities Aid Association and its local tuberculosis and public health committees. Throughout the years they have sponsored improvements in health legislation and have worked for the establishment of county health departments. From time to time they have received an astonishing amount of criticism which they have borne with equanimity

This was especially pronounced during those stormy days of the Cattaraugus County demonstration and the troubled aftermath. The Association's linkage with the demonstration, by some curious transference, was supposed to link them with the demonstration director's ideas on health insurance.

At any rate, among other objections leveled at county health departments were that they would be run by the State Charities Aid Association and that they would be an opening wedge for what Dr Frank W Laidlaw, State District Health Officer, used to call "state medsun" It has taken a good while to free the medical mind of these delusions and to recognize the true worth of the local committees and its central office. They constitute a powerful force in molding public opinion for the good against the bad and in obtaining effective action.

Another force back of the legislation was the favorable attitude of the medical profession. The Medical Society of the State of New York had passed a resolution favoring county health departments some years before, I believe, during Dr. George Cottis' term as president, but I had seeing this represented a deference to Dr. Cottis rather than any real belief in the doctrine. Its reitenation by the House of Delegates, in 1944, gave strength to it and indicated a continuing favorable interest.

The fundamental reason for the existing favorable political and medical attitudes lies in the satisfactory experience with the county health departments that have been operating. The youngest of them is now nine years old, and with the exception of the early years of the Cattarau gus County demonstration they have lived up to the expectations. Even in the darkest days of the early 1930 s, when budgets were being out universally, those of the county health departments suffered less than most of the unorganized counties in their nursing service. Even in the darkest of those days, there was no movement to revert to the former part-time system.

This record has made its impression on the supervisors of other counties. I believe I am correct in saying that every supervisors committee that has visited county health departments has been favorably impressed by what they saw and heard regarding the establishment of the departments. Although this has rarely led to action at the time, its effect is being demonstrated now. Actual performance by going concerns has served not only to allay earlier suspicion but to demonstrate true worth.

This comment applies also to the improvement and expansion of our district offices. As I said nearly three years ago, they are "demonstrations of the worthwhlleness of qualified personnel and full time service." The quality of the men and women that the State Department of Health has been able to recruit and train over the past fifteen years has had a large share in setting the stage for autonomous full time service for the whole State

The better control of water and milk supplies, the better directed and supervised nursing services, and the improved handling of venered diseases and tuberculosis through the district offices have been visible throughout the State. These offices have given a wider spread to an understanding and appreciation of full-time, qualified service than would be possible through a smaller number of county health departments.

To those who have served in these offices, to those who have dealt with them, and to those who have benefited by their work, these offices need no justification. Apparently, they do need to be

defended elsewhere—among theorists more concerned with organization than performance Admittedly, compared with county health departments, these offices have shortcomings, as they have been financed and developed in this State.

We are aware of these shortcomings, some of which Dr V A Van Volkenburgh Assistant Commissioner of Health, recently enumerated in his paper at Ann Arbor, Michigan ¹ But to display a map indicating New York as a benighted territory with only three dispersed areas (outside the large cities and the district adjacent to New York City) having health service worthy of mention tends to become irritating

It is true that the Subcommittee on Local Health Units gives a fair picture of conditions in its written description of New York and supplies a word of caution "against drawing qualitative conclusions from these quantitative data," but the uncritical are quite likely to do just that 1:1 think it is not only unfair to the State but is, especially, unfair to the men and women who have been and are performing health services that compare favorably with those given in states plastered with "3- and 4-nece units."

I do not look with favor on another item in the Subcommittee's report, i e., that one recommending multi-county districts. I think it is much more sound to accept established minor civil divisions as they are, until more pervasive reasons cause them to be changed The rates of consoli dation and separation among such districts should be investigated and reported before being adopted as a policy The districts shown on the map of this report represent a desirable number of State districts, not autonomous multi-county "units." The difficulties in obtaining agreement in the first instance, the foreseeable contentions as to headquarters personnel, and budget, and the confu sion arising from a divorce seem more formidable and more wasteful than attempting to find good use for a full-time health commissioner in a county of less than 50 000

Dr Van Volkenburgh indicated 3 lines of development which would not only benefit the people of the county but would be satisfying to a qualified health officer! I quote from his paper

"One method is to establish a county general hospital with State and federal subsidy which would also house the county health department and county laboratory facilities, the health officer to serve in a dual capacity as superintendent of the hospital, with the aid of an assistant superintendent. Such an arrangement should provide desired coordination between preventive and curative services in the county. At least 8 of these counties lack satisfactory hospital bed facilities. For 1 of these countres, a plan, complete in

all details, has been prepared in accordance with the above suggestion

"Another method is the combining of the school medical inspection and nursing service with the work of the county health department. School services in this State are provided by local school boards through contract with local physicians and school nurse teachers. Such contracts could be made with the county health department.

"Still another method is intensification and more universal provision of public health services. It has been our experience that these small population rural counties have greater need of public health services and require more personal attention than do more populous and prosperous counties.

"It is believed that every effort should be made to develop single county health districts and avoid multi-county units in New York State. The economic factor has largely been removed by State and since such counties now can be reimbursed 75 cents for each dollar expended on health work. If more financial and is necessary, it is possible to supplement further with federal funds granted to the State."

These functions would bring the health department and especially the commissioner into closer relation with the public and the practitioners of the county It should materially improve the quality of the medical examinations and the follow-up examinations of children with defects, and, most of all, it should obtain a larger proportion of corrections of defects than has been usual The special services provided by the State Department of Health would be used earlier and more frequently, and I feel sure that arrangements would be made with the county medical societies for the use of the staff and facilities of the county hospitals to the advantage of both patients and practitioners It seems to me to be a challenging opportunity to one with sincerity, diplomacy, imagination tempered with common sense, and ambition controlled by good judgment

Up to April 1, 1947, 5 county boards of supervisors had voted to establish county health departments, 7 had requested surveys looking toward such an action, and 10 had shown an interest which may be translated into action in the not too distant future. The State administration has indicated its willingness to spend \$14,000,000 in aid of local public health work, including hospital care for tuberculosis. The State Department of Health is ready with whatever technical assistance it can give and is ready to aid in the difficult task of finding suitable personnel to give the quality of service the State deserves

It is hard to see how the State can go much further Its most effective propaganda will probably be in continuing good health work, improving it if possible, and in conferring with key people in the cities and counties that will be affected. The agitation and the initiative should come, as definite action will have to, from the people who will pay the local share of the cost and who will profit most by the service

Discussion

W A. Holla, M D, White Plains —I would like to discuss this paper from an angle somewhat different from that usually followed. You have heard from Dr. Godfrey how the situation appears from his vantage point. Let me explain how this same problem appears to one who is administering the actual operation and attempting to carry out the instructions from the Albany office, and how these two viewpoints vary.

These comments are based upon seventeen years of experience in a county health district, operating since 1930, under State aid with State Health Office The county health district district supervision population exceeds 300,000, and population densities range from 51 persons per square mile to over 11,000 persons per square mile, with an average of The area is 425 square miles The location is in 711 the New York City metropolitan area The county program is affected by proximity to New York City and about 40 per cent of our wage earners work in that city Frequently, the New York City program is at variance with state policies

The following are the chief criticisms as seen here I Authority for local control of realty subdivisions by county health department is without adequate basis in State law Local county control legislation was passed in 1934 Paragraph 89 of the Public Health Law, enacted in 1933, does not apply in Westchester

II The State policy relating to Article V, Public Health Law, entitled "Potable Waters," needs to be revised

- (A) The State is uncertain as to applicability to nonpotable waters
- (B) The application to industrial waste is not clear
- (C) The County sanitary engineers are not always consulted regarding approval of plans for sewage treatment
- (D) The application of the law to discharges of wastes "to the waters of the State" has been interpreted to include ground waters. This is not necessarily correct, since the law further limits such control to such discharges "in quantities injurious to the public health". This county issued 800 permits, in 1946, for small sewage disposal systems not approved by the State. None of these discharge directly into streams or natural bodies of water, yet our authority to issue such permits has been questioned.
- (E) Chapter VII of the State Sanitary Code should not require State approval of camp sewage disposal facilities by the State in counties or cities having sanitary engineers

(F) The new condition of State sewage discharge permit attempts to control industrial wastes by inferring their inclusion in the category of "Sanitary and domestic sewage."

 The county health department wants to conserve millions of dollars of investments in sanitary sewers designed only for sanitary sewage, not including in

dustrial wastes.

(2) The State has proposed discharge of industrial wastes to such sanitary sewers, rather than to natural bodies of water, after suitable treatment. This does not appear reasonable since

(a) Sanitary science can devise any degree of treatment needed for the protection of natural bodies of water

- (b) The State has long maintained an official attitude of indifference to the broad problem of industrial wastedisposal. If this policy is being changed local health units would appreciate the opportunity to discuss the local aspects of such problems.
- (G) The State laws relating to approval of public water supply systems should be consolidated

under public health laws.

- (1) Existing laws affecting such systems in clude the Public Service Commission Law State Conservation Law Public Health Law Sanitary Code and State town, village, and city laws
- (2) Existing laws requiring local regulations to provide adequate public health protection have loopholes or are not en
- 100000
- III Sanitary control of milk and milk products (A) State Department of Health control should not be subordinate to other laws, such as agriculture and markets or New York City Westchester Country had to obtain an injunction in 1946 to keep New York City from grabbing more than their share of the milk supply
- (B) The State Department of Health practically ignores animal disease control in dairy herds

 The present agriculture and markets program on mastitis is not coordinated

with health department work.

(2) The local county veterinarians' are employed under agriculture and markets law not health law There are no veterinarians, employed as such, in the State Department of Health.

(C) There is no State-wide dairy farm inspection

control program

 The development of a large number of adequately staffed county units may obviate a State-wide dairy inspection law but the coordination of control should be through or by the State Department of Health

8 Sanitary control of food production

(A) The State Department of Health has no program, except for restaurant sanitation, a relatively minor phase of this work.

- (B) Local health units cannot ignore problems rather they must work out their own program without State support and must achieve cooperation with other agencies, such as State agriculture and markets labor and education departments. Federal Food and Drug Administration, U.S.P. Health Service (shellfish), and the State Conservation Department (shellfish) Such agencies frequently shrink from contacts with local health departments because of the many mistakes and misunderstandings which have arisen as a result of the lack of uniform State food and drug control and the lack of support from the State Department of Health
- (C) Recognition of qualifications for sanitation personnel in the field of food control is expected in the proposed Section G Chapter VI of the State Sanitary Code which will probably be adopted shortly by the Public Health Council.

(D) Local food control programs are needed for the following purposes

- To provide information relative to food sources and sanitation of premises when it is necessary to investigate food-borne illness.
- (2) To maintain sanitary control of food plants to prevent outbreaks of food borne illness. No outbreaks of illness due to faulty bakery sanitation have occurred since 1934 in our county This is believed to be due to a number of factors. not the least of which is the inspection service, maintained by the Health Department. A similar parallel exists in the drastic reduction in sewage over flows which fifteen years ago were the principal source of complaint to the department. This reduction has been obtained by requiring approval and inspection of all small sewage disposal systems as they are installed.
- (3) To control food plant sanitation by other agencies, particularly the State Department of Agriculture and Markets, is not adequate in our area. Numerous 'actions' have been undertaken by the county health unit. It may be interesting to note that there is evidence that watering of milk has been increasing during recent years. Although this practice has been considered only as a violation of agriculture and markets laws, the fact romains that the bacterial quality of milk, delivered to consumers has steadily declined since 1942

V Integration of State Department of Health policies with local health programs

(4) Under State aid certain local activities have been listed as not reimbursable, i.a., insect and pest control weed control, control of air pollution and possibly other projects, such as participation in local housing programs or the establishment of local food analytical laboratories. (B) Chapter VIII, State Sanitary Code, relating to nuisances, is obsolete and impractical, yet it was the subject of a number of questions on a recent Civil Service examination for sanitary engineers

(C) Local health units are rarely advised of proposed amendments to State laws, directly affecting them, until the bill is passed

The State Department of Health is urged to recover much of the jurisdiction over environmental sanitation which appears to have been lost to other State agencies It is believed that the State Department of Health should have sufficient authority to

- (A) Control all types of sewage and industrial waste discharges
- (B) Determine the adequacy of and specify required treatment of all public water supplies
- (C) Establish a State-wide control of food and drugs, sufficient to supplement the Federal Food, Drug, and Cosmetics Act, with provision for local units to supplement local health programs
- (D) Establish State-wide coordination of local health programs and provide hason between local units, and between local units and all State or federal agencies with which they must coordinate their activities

Wendell R. Ames, M.D., Olean —Dr Godfrey has very nicely summarized the new legislation, regarding the establishment of county health departments and State aid to counties, and he has described the new impetus that has been given to the formation of county health districts in New York Most or all of us who work in counties so organized are stimulated by these events and derive a certain sense of satisfaction from them After all, we would not be in that type of organization unless we felt that it had something substantial to offer in the way of service to the community The county or full-time city health department is, of course, primarily a service organization

Those of us who operated small or medium-sized county health departments under the old provisions of the law find ourselves in the peculiar position of not noticing a great deal of change resulting from the new legislation This, I believe, is due to the fact that the new legislation did not The increasing affect us much, except financially costs of operation and the demand for new or increased services were counterbalanced, at least in the small and medium-sized departments, by the increase in the reimbursement rate But I wonder what pressure we would now be under if that increase in revenue had not become available when it did?

I do not feel able to comment on some of the other legislative changes In Cattaraugus County only the 2 cities, and 1 village which happens to be partly in an adjacent county, continue to have their own part-time health officers We have an excellent relationship with all 3, and I agree with Dr Godfrey that there is a definite place for part-time health officers I would emphasize, however, that full-time service has not yet been established and used enough, in spite of the excellent recent progress reported

There seems to be a certain amount of conflict between the urban and rural areas of many counties, and between adjacent counties Limiting the basic health district to a single county and providing for optional inclusion of the urban center or centers recognizes this intangible but very real situation

I would comment on another perhaps intangible

but real situation. The present legislation can be

still further improved, in my opinion The object of the establishment of a county health department is, as I see it, to centralize the major public health services of the local government units into an agency with the hope, usually realized, of getting better service Tuberculosis hospital and public health laboratory services may be included, often they are Whether to include them is a decision that must be made locally in the light of the available in-But the ceiling on State aid for both of these services is embarrassing to the administrator if he has the responsibility for them Obviously, it is easier to secure appropriations for items that are reimbursable at 75 per cent than for items reimbursed at 50 per cent or less The present law that provides for State aid to laboratories makes it possible for a city laboratory to contract with a county, and, jointly, they may secure \$15,000 in State aid, whereas if the laboratory becomes an integral part of a county health department, only \$7,500 in State aid may be secured Larger counties establish branch laboratories and in so doing circumvent this difficulty Smaller counties, however, may have this difficulty Where study shows that a laboratory should be an integral part of a county health department, the department should not be penalized for making a progressive move It should be

Dr Godfrey mentioned the present favorable atmosphere—medical and political—for county health departments and commented upon the effect of existing county health departments and the effect of the State district offices in creating this atmos-The district officers, particularly, should be commended for their excellent work The difficult 10b of coordinating several health services, organized at different levels of local government under different bodies, or entirely outside of the governmental framework, and then stepping in to fill the deficiencies, requires much more than ordinary training, ability, and initiative

A word of warning and a request Dr Godfrey's remarks about the stormy days of the Cattaraugus County demonstration indicate that all is not always sweetness and light I believe that a great deal of similar difficulty will be avoided by building our public health program on a sound basis of popular understanding It should not be sold to one or another powerful group in the community I would also like to see a much closer working relationship developed between the State Department of Health and the local full-time departments

References

Ibid p 214

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¹ Van Volkenburgh, V A Am. J Pub Health Sup 1 14 (Jan.) 1947 2 Emerson Haven Local Health Units for the Nation New York City Commonwealth Fund, 1945, p 204. 3 Ibid p 14

WILMS' TUMORS

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VILMS tumors are the most commonly encountered renal neoplasms of child hood, and it may be assumed that with a few exceptions kidney tumors of children, described as arcomas or carcinomas, belong to this type of malignant new growth. The complexity of the histologic picture accounts for the confusing terminology which includes terms like adenosarcoma, embryonal sarcoma, teratoma, myochondro, rhabdo-, or myxosarcoma and others.

Numerous theories have been advanced as to the origin of Wilms' tumors. It was Wilms idea that these tumors arise from scattered nests of undifferentiated germinal tissue which are deposited in the kidney anlage during the earliest period of embryonal life.1 In contrast, Ewing assumed that Wilms' tumors are derived from the renal blastema or nephrotome after the organ luss been separated from the rest of the urogenital ridge of the embryo A theory advanced by Dean and Pack is of particular interest because of its clinical and prognostic implications. They believe that Wilms' tumors may originate at various developmental periods of fetal life. The formation of smooth or stricted muscle fibers, cartilage, fat, as well as tubular and sarcomatous cell elements, is attributed by them to the multipotency of the urogenital ridge, while primitive glomeruli or primitive renal tubules may be identi fied if the higher developed nephrotome is the predominant constituent source of the tumor

Although Wilms' tumors may be found in any portion of the kidney, they are most frequently encountered in its lower pole. They are best com pared to biologic parasites which cause destruction of the host organ within a short space of During the early stages of the disease the tumor is surrounded by a dense fibrous tissue capsule which separates it from the kidney pa renchyma. This capsule is intimately connected with the renal substance, making it impossible to separate the tumor from the kidney without tearing away some of the renal tissue unlargement with progressive compression atrophy of the remaining kidney parenchyma is the rule. Some of these neoplasms may attain enormous proportions, and, although located retropentoneally, they may occupy the entire abdomen with resultant displacement of intestines, liver, or spleen. Elevation of the dia

phragm on the affected side is common. Wilms' tumors weighing over 30 pounds have been reported. However, these monstreames are exceptional, and tumors of infant head size represent the dimensions more frequently encountered (Fig. 1)



Fig 1

Rupture of the tumor capsule may occur fairly early, but in some instances the tumor attains considerable size before the continuity of the capsule is destroyed. As soon as the capsular barrier has been broken, rapid aggressive invasion of the neighboring structures occurs. Involvement of the remaining kidney substance, kidney pelvis, and hilus with its blood and lymph vessels is common, as is invasion of the adjacent organs. such as the duodenum, pentoneum, vena cava. diaphragm, and even the ureter Distant metastases, usually blood-borne, occur, almost invariably a short time after the tumor has perforated the capsular barrier Metastatic involvement of lungs and liver is most common, but any organ. including the skin, may be the site of metastatic

On section, Wilms' tumors present a glistening appearance. They are grayish-pink in color In large size tumors discoloration of the growth, due to hamorrhages and necrosis, is frequent. In these advanced stages, the neoplasms are bluish red in appearance, and they are of grumous or gelatinous consistency with interspersed areas of cystic degeneration.

Although Wilms' tumors comprise approxi mately 20 per cent of all malignant neoplasms in children, their occurrence is rather uncommon?

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By way of illustration, Memorial Hospital reports only 80 cases, Children's Hospital, Boston, 60, and the Mayo Clinic, 39, 52 cases were collected by Campbell from the services of various New York hospitals 3-6 Our records reveal 16 children with Wilms' tumors admitted to the Roswell Park Memorial Institute during a thirty-year period This represents an incidence of only one case in about 3,500 patients admitted

A study of our comparatively small series of cases indicates essential agreement with statistical data presented by some of the aforementioned authors There was no significant difference in sex or the side involved Nine of the 16 patients were boys and 7 were girls The left kidney was the site of the tumor in 9 patients, as compared with 7 patients having right-sided lesions average age in our group of cases was thirty-five and eight-tenths months at the time when the first symptoms of the disease became manifest, with 9 of the patients ranging from two to four years of age The youngest patient was a newborn infant with metastatic tumor growth (Fig 2) and the oldest patient was eleven years of age

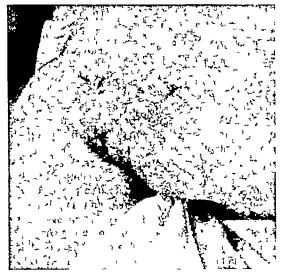


Fig 2

Signs and symptoms of the disease are almost invariably absent during the early stages of Wilms' tumors. Encapsulation of the neoplasm is the reason for the absence of hematuria, the most constant early symptom in cases of adult-type renal tumor. By the time a Wilms' tumor produces symptoms, it is almost always well-advanced.

Visible enlargement of the abdomen or a mass felt in one side of the abdomen represents the usual first manifestation of the disease. Such a mass may be detected accidentally by the mother or by the physician when examining the child for apparently unrelated symptoms.

Insidious growth of the tumor is the rule, but overnight development of a mass, due to massive hemorrhage into a previously undetected tumor, may occur occasionally 6 As the tumor increases in size symptoms develop as a result of compression or actual involvement of adjacent There may be pain, vomiting, jaunstructures dice, and changes in bowel habits, such as diarrhea or obstructive symptoms Fever, either of the intermittent or of the high continuous typhoidal type, is fairly frequent in occurrence Tortuous, dilated superficial abdominal veins, commonly associated with ascites and rapidly progressing cachexia, indicate the approach of the terminal stages

Urinary symptoms such as hematuria, frequency, or dysuria, occur mostly during the more advanced stages of the disease Hematuria need not originate in the tumor proper but may ensue as a result of congestion of the remaining kidney parenchyma ^{3 6}

The occurrence of hypertension as one of the symptoms of renal embryomas has been described more recently by various authors ¹⁻¹⁰ This symptom is attributed to the liberation of pressure substances by the tumor, but may also be the result of renal ischemia ^{8 9}

The symptoms encountered in our series of 16 cases were, in the order of frequency mass in loin, 13, abdominal pain, 8, gastrointestinal disturbances 3, fever 3, hematuria 3, and metastatic skin tumor, 1 Six of the 16 patients had demonstrable distant metastases at the time of diagnosis, and 8 of the remaining 10 cases had faradvanced primary lesions

The diagnosis of Wilms' tumors is rarely made during the early stages of the disease. As long as the growth is confined to its capsule and to the kidney, there are usually no local symptoms and the patient's general condition remains unimpaired. Only in isolated cases is early recognition of the disease possible, such as when suspicion is aroused by an acute incident as hematuria, sudden hemorrhage into the tumor, or pain due to torsion of the kidney pedicle.

In contrast, comparatively little difficulty is encountered in recognizing the tumor after it has progressed far enough to produce symptoms which warrant investigation. The presence of a mass in the kidney region is often sufficient evidence to arrive at a diagnosis of Wilms' tumor. While in some cases the tumor may be so large that it can be readily detected on inspection of the abdomen, there are others in whom examination under anesthesia is necessary before the tumor can be palpated. Urologic investigations consisting of excretory urography or cystoscopy with kidney function tests and retrograde pyelograms are essential to confirm or disprove the diagnosis

Also barium enemas and x ray studies of the gastrointestinal tract are of diagnostic value inasmuch as such an examination may reveal displacement or obstruction of the bowels due to involvement by tumor growth

It cannot be emphasized enough that one should not resort to aspiration biopsy, needle puncture, or exploratory bropsy, because such a procedure must cause destruction of the continuity of the tumor capsule, thus reducing the chances for possible cure. On the other hand, biopsy from a readily accessible metastatic lesion is not harmful, and its use should be advocated in certain cases as an easy method to establish the diagnosis. As an illustration, removal of a metastatic skin lesion, the only sign of the disease in a newborn infant, confirmed the diagnosis in one of our cases several weeks before the primary tumor was palpable.

Other signs and symptoms of renal embryomas, such as fever or hypertension, are not characteristic of this disease alone and thus are of limited diagnostic value. Diagnostic aid can be expected from Papanicolaou stains of the urnary sediment only in certain cases, namely after the tumor has invaded the kidney pelvis. In these cases it is possible to make a pathologically confirmed diagnosis. However, it must be kept in mind that such a method cannot yield results as long as the tumor is confined to its capsule.

Rapid progression of the lesion after onset of symptoms is the rule. This accounts for the fact that comparatively little time elapses in most of the cases between initial symptoms and recognition of the lesion. In our series of 16 patients, the average duration of symptoms up to the time of diagnosis was only two and a half months. In 13 (81 per cent) of them, diagnosis was made in less than two months after onset of symptoms, and in the remaining 3 cases, symptoms persisted for three, nine, and thriteen months before the diagnosis was made. Yet, in spite of comparatively little delay in diagnosis, it was found that 7 of the 16 patients had metastases at the time of diagnosis.

These data are in agreement with those of Campbell, who found that the time interval between onset of symptoms and diagnosis was less than two months in 37 (78 per cent) of 47 patients. Yet, in spite of the shortness of time elapsed between initial symptoms and diagnosis, it must be understood that one cannot consider these 'carly' diagnoses. It has to be kept in mind that, with few exceptions, every case of Wilms tumor is more or less advanced as soon as it changes from the asymptomatic to the symptomatic stage. This, together with the fact that renal embryomas consist of embryonal cells which possess an inherent property for rapid and destructive

growth, account for the poor prognosis in any case of Wilms' tumors

Figures presented by various authors indicate an ultimate mortality rate of more than 90 per cent with the duration of life lasting from five to eighteen months from the time of diagnosis. 6,11 12 Slightly better results are reported by Priestley and Schulte, who reported a five-year cure rate of 15 per cent (39 cases) Ladd and White claim cures in approximately 25 per cent (60 cases) of their patients.4 The results accomplished in our series of cases are most discouraging. Fifteen of our 16 patients died of the disease, and only one patient has remained alive and well for more than ten years. The average duration of life in 14 cases in whom the time of death could be deter mined was seven and eight-tentlis months after diagnosis Eleven of them died within the first six months and 3 patients died after fifteen twenty-seven, and thirty three months, respectively

It is obvious that the unsatisfactory results obtained are most challenging to the medical profession. While no disagreement seems to exist at the present time as to the pathologic characteristics, diagnosis, or clinical course of the disease, there is persistent controversy regarding the most promising method of treatment of Wilms' timors. Among the common forms of therapy employed are (1) nephrectomy alone (2) irradiation alone, (3) irradiation followed by irradiation and (5) nephrectomy preceded and followed by irradiation.

It is difficult, if not impossible to state which method of treatment should be given preference or in which order a combination of treatments should be carned out. The number of cases receiving identical treatments which form the basis for various statistics is too small to permit conclusions as to the superiority of any one procedure. Ladd and White, who believe that their unusually high five-year cure rate was due to employment of early ligation of the pedicle while carrying out transperitoneal nephrectomy with out preliminary irradiation, have remained unduplicated by previous or subsequent statistics, based on a substantial number of cases. It cannot be determined at the present time whether their favorable results should be attributed to coincidence or to the method employed. It is of interest in this connection that Donn attained an identical five-year cure rate in 5, or 25 per cent of 20 patients who received irradiation alone. These quite controversial observations indicate that coincidence may play a part in influencing the author's opinion, and caution should be employed in accepting conclusions as long as they must be based on a limited number of patients.

It seems best to be less dogmatic about the method of treatment in Wilms' tumors should consider each case individually with a view toward selecting that kind of therapy which appears most promising for a particular case Factors such as size of the tumor and apparent rate of growth are equally as important as the patient's general condition and the surgeon's skill and experience in handling this type of le-Regardless of the method of therapy to be employed, it remains the object of treatment to accomplish removal or complete destruction of the neoplasm before metastases occur static spread of the disease is a constant danger and cases are on record in which metastases developed during the course of a short clinical Once the tumor has metastasized, investigation the prognosis is hopeless, and no more than palliation can be expected from any form of therapy

We believe that immediate removal of the tumor, followed by postoperative irradiation, should be attempted in all patients with small, and apparently still encapsulated, Wilms' tu-Preoperative irradiation in such cases is of doubtful value, and delay of surgery may permit metastatic spread However, in patients with fairly large or apparently inoperable lesions, preoperative irradiation may reduce the size of the tumor to such an extent that it becomes operable In deciding whether or not preliminary irradiation should be employed, it must be kept in mind that a Wilms' tumor is usually found to be more extensive at the time of operation than was anticipated during the preoperative examina-If preoperative irradiation therapy is employed, no time should be lost in attempting surgery as soon as the neoplasm has regressed sufficiently to justify operation. The transperitoneal approach is preferable, because it offers not only better exposure, but it makes it possible to ligate the pedicle before the tumor is manipu-Postoperative irradiation should be employed in all these cases If, however, a tumor is found to be inoperable, it is not feasible to carry out partial removal of the growth. Such a procedure would not benefit the patient, but rather would invite disaster

It is in the group of inoperable tumors that radiation should be employed to the limit of tolerance. Treatment is given through 3 portals, using anterior, lateral, and posterior fields, starting with daily increments of 50 roentgens to each portal with a view toward increasing the daily dosage, if treatment is well tolerated. If possible, a total of 4,000 to 5,000 roentgens should be delivered into the center of the tumor, but the patient's general condition and possible ill effects from treatment may often necessitate a change in the plan of therapy with regard to daily increment or total dosage. Yet, in spite of all

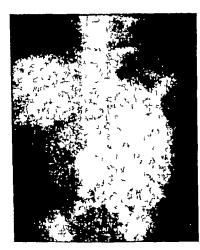
efforts, it must be understood that success or failure of radiation is only partially determined by dosage and technic employed. The immediate and remote results accomplished depend also upon the degree of radiosensitivity or radioresponsiveness of the tumor. Each Wilms' tumor presents individual variations in its response to irradiation. For instance, a tumor composed of immature cells can be expected to respond more satisfactorily to irradiation than a tumor consisting predominantly of adult-type cell elements.

Unfortunately, there is no way of predicting the degree of response which can be anticipated from the use of irradiation therapy in each case Only success or failure will supply the answer But the possibility that any Wilms' tumor might be radioresponsive or radiosensitive always justifies an attempt at irradiation therapy. By way of illustration, the following case will be reported briefly

Case 1—Baby P G, white girl, aged two, was admitted on August 31, 1937 At the age of ten months, the mother discovered a mass in the left upper abdomen, which increased rapidly in size One month later, hematuria and abdominal pain developed A transperitoneal exploratory operation revealed an inoperable Wilms' tumor Biopsy was made and the diagnosis confirmed Following the exploratory operation, the child received an undetermined amount of radiation therapy, which resulted in temporary improvement Later, on admission to the Institute, the patient presented a large nodular tumor which occupied almost the entire left abdomen Although ascites was present, no evidence of distant metasjases was demonstrable.

Treatment consisted of 200 kilovolt radiation, given through an anterior, posterior, and lateral field From August 31, 1937, to January 5, 1938, a total of 4,826 roentgens were delivered to the tumor by daily increments ranging from 50 to 131 roent-During the course of treatment, there was slow but steady improvement. The tumor regressed in size and two months after irradiation therapy, the ascites had disappeared. X-ray films of the abdomen revealed complete calcification of the tumor which continued to feel hard and nodular The patient gained weight and felt well, but in September, 1939, another course of irradiation treatment was given, since renewed activity of the tumor was suspected because of anorexia and From September 11, 1939, to October 27, 1939, 200 kilovolt radiation was employed, and a total of 1,445 roentgens were delivered to the tumor, using an anterior and a posterior field with daily increments of 94 roentgens

Ever since, the patient has remained in good health. She was examined last in January, 1947, at which time she felt well—Her general physique was that of a girl of her age (twelve years)—On palpation of the abdomen, there was still a hard, fixed, nodular tumor felt, which occupied a large part of the left upper abdomen—A flat film of the abdomen revealed no change in the size and shape of the calcified tumor, and a barium enema showed no displace-



Fra 3

ment or encroachment on the transverse or descending colon (Fig. 4)

This patient represents a ten-year cure, follow ing irradiation therapy alone. This proves that an attempt at radiation treatment may be well worth while in some cases of extensive but nonmetastatic Wilms' tumors. If metastases have occurred, irradiation treatment is of little value, because rapid development of new lessons is the rule, even while treatment is being directed against one metastatic tumor

Summary

Although Wilms' tumors comprise approximately 20 per cent of all malignant neoplasms in children, their occurrence is rather uncommon. Only 16 children with this type of tumor were admitted to the Roswell Park Memorial Institute during a thirty year period. This represents an incidence of only 1 case in about 3 500 admissions.

Pathogenesis, clinical course, symptoms, and diagnosis of the disease are discussed.

The prognosis of Wilms' tumors is poor with an ultimate mortality rate of close to 90 per cent. The dumtion of life averages less than one year after the diagnosis is made.

Removal or complete destruction of the tumor before development of metastases is imperative. No dogmatic rules should be followed in determining the method of treatment, but whatever form of therapy is best suited for each individual case should be selected.



Fig 4.

Immediate surgery followed by postoperative irradiation is advocated in small, movable tumors. Preoperative irradiation is advisable in fairly large or apparently inoperable lesions, thereby attempting to attain sufficient shrinkage to make the tumor operable. Removal of the tumor in such cases should be followed by supplementary postoperative irradiation. Inoperable Wilms' tumors should be treated by radiation alone Favorable results and even cures may be accomplished by irradiation in certam radiosensitive and radioresponance Wilms' tumors.

A ten-year cure of inoperable Wilms' tumor, following irradiation therapy exclusively, is reported.

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ENDEMIC FEATURES OF RICKETTSIALPOX

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MOST of the rickettsial diseases are characterized clinically by the occurrence of fever, headache, and other acute symptoms, and, in addition the appearance of a rash which is macular, maculopapular, or petechial

During the summer of 1946, an epidemic occurred in a housing development in Queens, in which the clinical picture resembled the one described above. A rickettsial disease was suspected, although there were many differences from the known rickettsial diseases.

The illness of most of the patients began with a primary lesion, a papule which grew in size until it was 1/2 to 11/2 cm in diameter on an erythematous base, the center became vesiculated and then dried, forming a black crust which dropped off about two and a half to three weeks later, leaving a small scar Regional lymphadenopathy was usually found About a week after the beginning of the primary lesion, there was an abrupt onset of fever, chills or chilly sensations. sweats, headache, and backache, followed in one to four days by a rash over the body, sometimes sparse and sometimes profuse The rash was characteristically papulovesicular in character, the vesicles firm and surmounting the papules, later drying and falling off The acute symptoms and the rash lasted about a week each After the fall of the temperature the patients made a rapid There were no complications and no recovery deaths

Laboratory data were generally negative except for leukopenia during the acute stage of illness. Blood cultures were sterile, sedimentation rates were normal or slightly elevated, urine specimens were normal except for some albumin in the first days of illness, blood sugar, nonprotein nitrogen, chlorides, and cholesterol were within normal limits, and Wassermann tests were negative. Biopsies of skin lesions showed a vasculitis, similar to the finding in other nickettsial diseases.

In the epidemiologic investigation of the Queens outbreak it was shown that age, sex, and occupation were not important factors in explaining the cause or spread of the disease, nor were water, milk, or food supplies involved. Domestic animals were readily ruled out as reservoirs Ticks were not found either in the houses or in the neighborhood, and the only insects found, in some

of the basements and in an impoundment, were mosquitoes (Culex pipiens) The two constant features were the presence of mice in the apartments, storage rooms, and incinerators, and the presence of mites on the walls of incinerators, in stored objects such as boxes and couches, and as ectoparasites of the mice

The results of the investigation have been published in a series of papers $1-\delta$ It was shown that the disease to which the name rickettsialpox was given was an acute infection caused by a hitherto undescribed rickettsia, named Rickettsia akari This organism was recovered from the blood of 2 patients early in the disease, as well as from 6 pools of bloodsucking mites (Allodermanyssus sanguineus) found in the buildings where the outbreak occurred, and also from one of a number of mice (Mus musculus), trapped in the buildings Complement fixation tests, performed with serums from patients in the presence of rickettsialpox antigen (a strain of R. akari recovered from one of the patients), were negative early in the disease but became positive about the second week, the titer increasing during convalescence The reactions were specific, since such convalescent serums gave negative complement fixation reactions with antigens from a number of other viral and rickettsial diseases, the serums of normal individuals, as well as those of individuals with other diseases, gave negative reactions with rickettsialpox antigen An exception should be noted in the case of Rocky Mountain spotted fever, the sera of about 80 per cent of the cases gave positive complement fixation reactions with the antigen of Rocky Mountain spotted fever, but in lower dilutions

Another characteristic of the disease was the negative Weil-Felix reactions with convalescent serums. All the other rickettsial diseases in which a rash is one of the clinical features give a positive agglutination reaction with one of the antigens of Bacillus proteus. Epidemic and endemic typhus give positive reactions with OX 19, Rocky Mountain spotted fever and Boutonneuse fever with OX 19 and OX 2, and tsutsugamushi fever or scrub typhus with OX K, but convalescent serums from cases of rickettsial-pox did not agglutinate any of the B proteus fractions except occasionally in very low titers.

It is reasonable to believe that the cycle was somewhat as follows Mice thrived and multiplied in incinerators and other parts of the build-

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ings where there was food and warmth, they acted as animal reservoirs for infected mites which attached themselves to, and fed on the mice. The infected mites were accidentally introduced into human dwellings, probably by the mice, and obtained a blood meal from the humans when they were unable to get it from the animal reservoir Rickettsine were introduced into the humans either by the bite of the akarid or by the rubbing of his feces into the skin result, a primary lesion occurred at the site, and the clinical symptoms of rickettsialpox followed

At the beginning of the investigation in Queens the epidemic appeared to be sharply delimited to one small group of houses No cases occurred in the immediate vicinity, nor were any heard of in the rest of the borough. Soon, however, as physicians learned of the syndrome, reports of suspected cases began coming in from widely These were all scattered parts of the city investigated At present we have records of 54 definite cases, all unrelated to the Queens epi demic. They are spotted on the accompanying An examination of the map shows map (Fig 1) the wide distribution of cases in the city were found in four of the five boroughs often far removed from each other As a matter of fact the first cases that were seen in the city, aside from the Queens outbreak, were in a group in the northeastern part of the Bronx a distance of



Rickettsialpox spot map of New York City (Staten Island omitted)

about 25 miles from the region of the outbreak across the East River The physician who noti fied us had seen 10 cases over a period of a few years in one large apartment house and had heard of several more Since then, 2 more cases have occurred there On the map only 4 cases are indicated, since these were the only ones observed by us In addition to typical clinical symptoms, all 4 had a positive complement fixation test for nekettsialpox. In this house, as in the Queens houses, mice were abundant, and mites (Allodermanyssus sanguineus) were found in large numbers on incinerator walls. Mice were trapped in this house, and the blood serum of one of them gave a positive complement fixation reaction for rickettsialpox in a titer of 1 64

Although the cases are distributed over a wide territory, they tend, nevertheless, to group Manhattan, there are 5 groupings On the lower west side 6 cases occurred over an area of about 10 square blocks in the middle west section, 7 cases were seen in a similar area, on the lower east side, 5 cases were observed in an area of 6 square blocks, and an additional 3 cases can be added if the area is extended a little in the middle east section of the borough, 10 cases were investigated in an area of about 25 square blocks. with smaller groupings within the area, at the northern end of the island 2 cases were reported within a few blocks of each other

The groupings in the Bronx are also readily seen on the map In the northwestern part are 4 cases in 1 building, with probably 8 more in the same building, reported to, but not seen by us. This group has already been discussed. In the lower middle part of the borough 3 cases were seen in 1 building a probable fourth case was not seen by us during the illness and a blood specimen for complement fixation was refused case has, therefore, not been spotted on the map Three other groups of 2 cases each are readily observed 2 m the northern section of the borough and 1 in the lower western part.

Only 3 cases were reported in Brooklyn, and these were widely spread In Queens only 1 case was found in addition to the cases which occurred in the outbreak previously reported This case is in a part of the borough far removed from the site of the outbreak It is interesting to note that cases occurring in different houses had no relationship to each other except propinguity In some of the houses, however, multiple cases did occur in families This was quite marked in the Queens outbreak and has been discussed elsewhere, it was observed in three instances in Manhattan and the Bronx, where 2 cases occurred in 1 apartment in each instance.3

The diagnosis of the cases was basted chiefly as in the epidemic in Queens, on the typical clinical findings In about two thirds of the cases it was confirmed serologically by a positive complement fixation reaction for rickettsialpox with serums taken from patients during the convalescent stage A further serologic test showed the absence of agglutinins for B proteus OX 19, OX 2, and OX K in such serums. In some of the cases it was possible to obtain a specimen of blood in the acute stage and another during convalescence. The results in 13 such cases are shown in Table 1.

TABLE 1—Complement Fixation Tests for Rickett stalpox on Serums Taken Early and Later in the Disease

Name	Date of Onset	Date of Specimen	Titer of Complement Fixation
DG	Aug. 16, 1946	Oct. 23, 1946 Jan. 14, 1947	$\begin{smallmatrix}1&32\\1&8\end{smallmatrix}$
I M	Aug. 20 1946	Aug 30 1946 Sept 11 1946	$\begin{array}{cccccccccccccccccccccccccccccccccccc$
S J	Sept. 24 1946	Sept 30 1946 Nov 18 1946	0 1 128
мс	Sept 27, 1946	Oct. 3 1946 Oct 16 1946 Nov 6 1946	1 128 1 128 1 8
M D	Oct. 1 1946	Oct. 8, 1946 Oct. 25 1946	0 1 256
CR.	Oct. 18 1946	Nov 3 1946 Jan. 8 1947	0 1 32
WR.	Oct. 21, 1946	Oct. 30 1946 Nov 15, 1946	1 4 1 512
FK.	Oct. 21, 1946	Oct. 24 1946 Nov 25, 1946	0 1 512
DO	Nov 7, 1946	Nov 13 1946 Jan. 11 1947	0 1 256
PR.	Nov 11 1946	Dec. 9 1946 Jan. 8, 1947	1 16 1 32
A. A.	Nov 20 1946	Nov 25, 1946 Dec 9 1946	0 1 64
L. Z	Nov 26 1946	Jan 2 1947 Jan. 22, 1947	0 1 128
мт	Jan. 26 1947	Jan. 31 1947 Mar 12 1947	0 1 32

It will be noted that in 6 instances no complement fixing antibodies for rickettsialpox were present in the first specimen, taken during the first week of illness, but that significant titers had been achieved when the later specimens were taken In 1 instance (M C) a specimen obtained on the sixth day of illness already showed a titer In another case (W R.) a blood specimen obtained on the ninth day had a titer of 1 4 which rose in two weeks to 1 512 case (P R.) a specimen, taken twenty-eight days after onset, had a titer of 1 16 which rose to 1 32 a month later In still another case (I M) a blood specimen, obtained ten days after onset of symptoms, had a titer of 1 32 which had not changed twelve days later On the other hand, complement fixing antibodies for rickettsialpox were not present in C R in the first specimen, taken sixteen days after onset, but were found in serum taken two months later, and in L Z the complement fixation reaction was negative five weeks after onset, but was positive in a titer of 1 128 ten days later

Our data do not indicate how long high titers of complement fixing antibodies are maintained That the titers may decline after several months was indicated by D G, whose serum titer was 1 32 two months after onset of illness and dropped to 1 8 some three months later. In the Queens epidemic there was also a small number from whom a specimen was obtained several months after the illness, and here, too, a decline in titer of complement fixing antibodies was noted

It has been shown that blood obtained from mice in the Queens epidemic showed significant titers of complement fixing antibodies for rickettsialpox, although no such antibodies were found in laboratory mice nor in those trapped in Virginia ⁵ We have begun to trap mice in the houses where cases occurred in the other boroughs. To date, mice have been trapped in only 3 of these houses. In 2 of them significant titers of rickettsialpox complement fixing antibodies were found in the mice.

Comment

The occurrence of isolated and small groups of unrelated cases of rickettsialpox in widely scattered areas of the city indicates that the disease is endemic in New York City Epidemics like the one in Queens probably depend on a number of factors, among which are the presence of food and warmth on which mice can thrive, a sufficient number of infected mites, and a large group of susceptible humans Incinerators played a part in keeping the outbreak alive in Queens This was due to the fact that food was almost always present in them, so that mice were attracted to them and acted as animal reservoirs for the mites. found in large numbers on incinerator walls, and as ectoparasites on the mice The firing of the incinerators did not disturb either the mice or the mites unduly, since there were sufficient openings between the bricks lining the incinerators for the animals to escape into the wall spaces interesting to note that a similar situation existed in the Bronx where about a dozen cases were seen by a physician in 1 house A fair percentage of the other houses where cases occurred had incinerators

It should not be inferred that incinerators play a necessary role in the spread of the disease No incinerators were found in a number of the houses where cases existed The home in the lower Bronx where 3, and possibly 4, cases occurred was an old-fashioned tenement house without an elevator or an incinerator However, there were plenty of mice in the cellar, halls, and apartments There were also several uncovered garbage cans in front of the house which had apparently been there for a considerable time

There are many old-line tenement houses in New York City, and mouse harborages can be found in most of them Remnants of food are frequently seen in halls, cellars, and yards The collection of garbage is taken care of in one of several ways the tenant branes his pail down to the cellar and empties it into large cans, or the janitor goes through the house collecting the pails at each apartment, or the tenant sends his pail down to the cellar on a dumbwaiter method is used, garbage is spilled and becomes a good food source for mice. What often is not realized is that in modern houses which are kept fairly clean, mouse harborages may exist in incinerators which are not fired frequently and completely At any rate, in all houses where cases occurred, mice were plentiful In some instances. tenants had not seen any in their own apartments but had seen them in the cellar or halls, in others, mice had been seen repeatedly in the apartments

It is quite probable that the disease has existed in endemic form for some time in New York City Several physicians to whose attention the syn drome was brought recalled seeing several cases in the past few years which they were unable to diagnose, or which they called Brill's disease or atypical chickenpox, and which in retrospect appeared to be cases of nokettsalpox. Whether such cases exist in other parts of the state or country, we shall probably soon learn.

An epidemiologic method for discovering the extent of infestation in any community consists in making surveys of nice. They can be trapped alive in various sections of the community and their bloods examined for complement fixing antibodies for rickettsnalpox. At present this plan has been put in operation in New York City

To make a diagnosis of a case of rickettsialpox one should observe the clinical symptoms described, an initial lesion, followed in about a week by an acute onset with fever chills, headache and backnehe, and a papulovesicular rash. The blood specimen should be taken during antibodies of rickettsialpox and for agglutination with B proteus. Wherever possible, 2 specimens of blood should be taken, I early in the disease and I in convalescence. In this way a rising tuter may be demonstrated.

Control measures should be undertaken whereever the disease occurs, such as the scaling off of
harborages, possibly the trapping of mee, campaigns to keep garbage cans tightly covared and
to exercise care in the conveying of garbage from
the tenant a spartments so that none is spilled in
hallways and cellars. In houses where incinerators are used, care should be taken that they are
properly lined, that there is no accumulation of
food in the compartments, and that firing is complete and frequent. At present the public health
aspects of rickettsialpox are not serious enough
to require drastic measures. Should this occa-

sion arise, thought should be given to the development of a prophylactic vaccine and to the use of D.D T in the homes and on individuals exposed.

Summary

The clinical features and laboratory findings of rickettsialpox are discussed. An analysis is made of 54 endemic cases in New York City. It is pointed out that the cases were widespread in different sections of the city but tended, nevertheless, to group. A method of survey is indicated, and control measures are discussed.

Discussion

Philip J Rafle, M D, New York City—I am pleased to open the discussion of Dr Greenberg's presentation of Endemic "Rickstitailpox," because this new subject should be of interest to physicians

and health officer epidemiologists.

Occasionally we hear generalizations to the effect that communicable disease control is attaining a place of minor importance in public health practice Even though there has been appreciable control of some of the more common preventable diseases there are still unexplored and unexplained conditions obviously communicable to which the epidemiologic approach and new laboratory technics need to be applied. I have in mind the problem of the atypical pneumonias and diarrheal disease in the newborn it needs no emphasis that as the commoner conditions are brought under control we will have to direct our attention to these not well-defined or well-understood diseases. These are largely in the field of diseases transmitted from animals to man. Communicable disease control is and will continue to be fundamental and basic in organized public health practice Therefore; it is gratifying to have evidence of such epidemiologic approach to an entity such as rickettsialpox presented to us in support of this belief

Rickettaial disease is not a rarity in New York State. Endemic typhus or Brills disease has been described and reported in New York City There is some question as to its origin, and it is believed that the disease, as manifested in New York City was an exacerbation of old world typhus. This is based to some extent on the observation that the individuals so affected were Central Europeans and had acquired their primary disease prior to emigrating to the United States.

Since 1913, Rocky Mountain spotted fever has been recognized as endemic in eastern Long Island. There has been slow progress in its spread westward on Long Island, but last summer a case, indigenous to Brooklyn, was recognized in Brooklyn. The dog tick, Dermacentor variabilis has been involved in this ricketitaid disease. There is ovidence that dogs in the endemic area have a high titer of complement fixing antibodies against Rocky Mountain spotted fever ricketitaid antigen. To the practitioners of medicine in southeastern Suffolk County Rocky Mountain spotted fever presents no particular difficulty in its diagnosis, but in other areas in which to cours infrequently the disease is often confused.

with other conditions presenting "rashes" As pointed out by Dr Greenberg, the Weil-Felix reaction with certain strains of B proteus are negative early in the disease but increase in titer in the second week. The Weil-Felix reaction offers a means of differential diagnosis from rickettsialpox.

During the coming spring and summer season the State Laboratory will perform the highly specific complement fixation test on positive agglutinations by Weil-Felix reactions, thus making available to us an additional aid for clinical differentiation. It is strange that in the face of the fact that Rocky Mountain spotted fever has been observed on Cape Cod and the Atlantic coast south of Long Island, it has not originated, as far as we know, on the mainland of New York. Ticks capable of transmitting the disease are present, at least to my knowledge, in Westchester County

This brings to point that often we have seen eruptive fevers that are puzzling On the basis of our knowledge of the exanthemas, I feel we have been inclined to describe them as atypical of the disease it most closely resembles Rickettsialpox was considered by some as atypical chicken pox I am sure that we have had similar experiences in classifying the unknown as atypical this or that these missed diagnoses come back to haunt us, as for example, smallpox I believe that it was Dr E S Godfrey who stated that the essential prerequisite for an epidemiologist is that he must possess more than a modicum of skepticism I feel that, perhaps when we approach these apparent atypical manifestations, we should be more skeptical of the conclusion, we should approach the problem epidemiologically, and we should utilize the newer technologies developed in the laboratory I think we will be rewarded by disclosure of conditions expected to occur in the tropics or other remote places rather than in New York City

F R. Weedon, M D, Jamestown—It is a rare privilege to witness the discovery of a new disease It is a gratifying thing to observe the smooth pattern of efficiency with which many groups of specialists, private physicians, and government experts have worked systematically to solve an intricate problem which presents so little primary data for study

A large number of people have worked on this situation private practitioners, health officers, epidemiologists, immunologists, pathologists, entomologists, bacteriologists, virologists, and many others

The difficulty of recognizing man's enemies appears to increase with the decrease in size of those enemies. Any cave man knew enough to stay away from the head end of a woolly rhinoceros, but we need a physician and a bacteriologist to avoid the small bacillus properly.

Rickettsial diseases have followed the curve A further step down in size has resulted in a large increase in man's expert body guards. It seems to me that this is logical and must be accepted

If you agree with me in this generalization, you may accept the probability that laboratory procedures will also become more intricate in study of the rickettsial diseases Of his early cases Dr Green-

berg says that laboratory data were generally negative except for the complement fixation reaction

The complement fixation test is, we believe, the most practical diagnostic laboratory procedure available in study of rickettsial disease, and our experience with typhus fever has convinced us that the quantitative complement fixation test of Wadsworth, Maltaner, and Maltaner is by far the most promising technic of this test. It is more elaborate, to be sure, but it is so much more precise and at the same time so much more flexible that we feel that, in the intricate work of diagnosis of rickettsial disease, this form of the test is of the greatest value

Florence M Varley—Titration of the antibody content of serum, as measured by the complement fixation test developed by Wadsworth, Maltaner, and Maltaner, is based upon the point of 50 per cent hemolysis of the sheep cells used as indicator. The amount of complement which will hemolyze half the cells can be figured from any degree of partial hemolysis obtained, because after proper adjustment of reagents an S curve results from varying amounts of complement.

This means that with constant amounts of antigen and antibody the amount of complement which will hemolyze 50 per cent of the cells bears a constant relationship to the amount that yields 40 per cent, or 60 per cent, or any given degree of partial hemolysis

In our work with typhus fever, as well as in past work with syphilis, the need for refinement of the antigen was demonstrated. With crude extracts the relationships do not hold, the S curve cannot be obtained, and results are not reproducible. Fluctuating results also occur if the amounts of antigen used are not titrated with antiserum to yield maximal fixation of complement. This preliminary work must be done carefully.

In the work with typhus, all this was followed through We found our relationships and were able to reproduce results Nevertheless, different series of antigen gave very different titers with the same antiserum, while all evidence that this might be due to strain variation was lacking. Even the difference between epidemic and endemic typhus tended to disappear

It might be that further study of rickettsialpox with more strains and different preparations of antigens will reveal either a closer relationship to Rocky Mountain spotted fever or even greater differences between the 2 diseases antigenically

We believe that the quantitative complement fixation test is the most practical and most promising of all the laboratory tests for the study of the complicated field of virus and rickettsial diseases which we seem to be entering

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COUNTY TUBERCULOSIS HOSPITALS

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(From the Tuberculosis Control Division New York State Department of Health)

IN discussing county tuberculosis hospitals, a program limited by the 4 walls of a hospital build ing and concerned only with the medical care of patients may be presented. In New York State, however, a presentation of this sort would fall far short of a true portrayal of the actual services of the county hospital and its contributions to the tuberculosis control program.

For more than three decades the superinten dents of many of the county hospitals have pioneered in the development of services which not only have emphasized in the minds of the people the importance of the county tuberculous hospitals, but also have enhanced the community's contribution to tuberculous control If the benefits realized from these services had been limited specifically to tuberculous, the funds expended and the work performed would have been more than justified, but throughout the years other aspects of both personal and public health have been favorably influenced Medical practice, in general, has been favorably influenced, either directly or indirectly, by the services of the county tuberculosis hospitals. Such services embrace the participation of the superintendents in county and state medical society programs including graduate education, the chest consultation service available in many counties and not limited to tuberculous diagnosis and the devel opment of a reciprocal service between the practicing physicians and the county sanatorium The development and growth of public health nursing is in part built upon the foundation laid by the tuberculous nursing service From the viewpoint of health education, it is impossible to estimate how far-reaching has been the influence of the hospital and clinic service of the county

From the viewpoint of the public, the buildings and service of a tuberculous hospital are symbols of disease prevention and health conservation. The public has come to realize to an appreciable degree that one of the main purposes of a tuberculosis hospital is to segregate a person with a contagious disease. This awareness of the man on the street that certain diseases are "catching" cannot help but influence personal hygiene favor ably The health teaching, too, as informal as it may be at many cheat clinics, deserves mention

hospitala.

One measure of stewardship is the death rate from this disease. In 1009, when counties first were given authority to establish tuberculosis hospitals, the tuberculosis death rate for upstate New York was 145 7 per 100 000 population. In 1946, the provisional resident rate was 30.2 This represents a decline of about 79 per cent. In spite of this decline, the fact that more than one-half of the deaths occur during the most productive years of life presents a serious challenge.

Consideration also must be given to the influ ence of improved health on our social and economic structure Obviously, the cost to society of tuberculous with all of its intangible by prod ucts, cannot actually be measured by any known vardstick. Although the tuberculosis hospital is a major factor in contributing to the improvement in health by preventing tuberculosis, its service favorably influences other health problems. In the field of scientific progress, medicine including that concerned with chest diseases, has assumed a conspicuous place Physicians, including chest specialists, have been provided with scientific tools which have made it possible for them to replace empiricism and passive methods of expectancy in the treatment of tuberculosis with the application of scientifically known preventive diagnostic, and therapeutic measures.

New and promising horsons have been opened in the field of public or community health. The masses of people are better informed on matters of health conservation. Public opinion has assumed a more positive character about community needs for the prevention of disease. More and more people not only recognize these needs, but also actively promote and support public officials in improving environmental sanitation and other public health services. New discoveries and advances in chemistry, bacteriology immunology, epidemiology, and pathology, together with progress in the social sciences and an encouraging renaissance in the practice of the art of medicine, complete this mosaic of prevention and cure.

Since public health is but the composite of personal health, it is essential, if progress is to be realized that we integrate more completely the practice of medicine with the administration of public health. The tuberculous hospital in this state has shown the way, and it is apparent in this specialized field that there is a constantly growing, better understanding between the private practitioner of medicine and the practitioners of public health.

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, Section on Public Health, Hygiens, and Sanitation, May 5, 1947

In the organization of a tumor clinic one of the first requirements is that there be an earnest desire on the part of the hospital staff to conduct a clinic. In addition, such a project cannot be successful unless it receives the full support of the entire staff. The members of the tumor clinic staff should consist of a surgeon, internist, radiologist, and pathologist. Members of the other specialties, as well as the entire staff membership, can and should participate in the tumor clinic conference. Every member of the staff should consider himself an integral part of the tumor clinic, because everyone has something to contribute.

The clinic should be conducted in a hospital because of the facilities available for diagnosis and A room of the hospital, equipped so that the examiner can do a complete physical examination, is necessary Facilities for biopsies, blood tests, and blood counts should be provided There also should be a waiting room, a hall can be utilized for this purpose Some clinics require that all patients be referred by physicians, while others allow patients to come to the clinic and send a report of the findings to the physician of the patient's choice The referring physician always remains in control of the patient, the advice of the clinic can be accepted or rejected as the referring physician deems wise The services of a nurse and secretary also are required in a tumor The nurse can aid in the preparation of the patient for physical examination as well as in performing biopsies and other required nursing The secretary can make and keep the records, make appointments, transcribe follow-up notes, prepare and send reports to the referring physicians, and perform all secretarial duties pertaining to the clinic

Histories and physical examinations can be obtained by a resident of the hospital or one of the younger physicians practicing in the com-The time of the tumor clinic group, munity usually composed of busy practitioners, should not be occupied by routine physical examinations and history taking Such duties can be performed the day before or just prior to the confer-The salient points can be enumerated to the clinic group, but the group should examine the patient and each give his opinion as to diagnosis and the treatment indicated If the diagnosis is not readily apparent, it is the responsibility of the tumor clinic staff to suggest and order those diagnostic procedures which will permit a positive The patient who has been treated should return to the clinic for follow-up observa-This is as important as is the initial diagnosis and treatment It is a safeguard for the patient and also allows the physician an opportunity to evaluate the type of treatment which was given

It is thought by some that a tumor clinic is only for indigent patients. That is erroneous. The clinic renders a consultation service to the physician and the patient whether the patient is indigent or otherwise. Some clinics require a fee for the services rendered, whereas most extend this service to the patient without charge, considering it a service of the staff and hospital. Added diagnostic procedures sometimes required to make a diagnosis are borne by the hospital, welfare organization, or the patient. Thus, local control of administration of the individual clinic is maintained, and problems are solved in accordance with existing local conditions.

There is no definite rule as to the hours for the clinic conference, but it should be given serious consideration. The time of the meeting should be that which will enable the largest number of physicians to attend. The number of meetings per week or month will depend entirely on the case load. Some of the large clinics meet 4 times a week, smaller ones twice a month. In many clinics the schedule of cases is posted on the bulletin board for the information of the staff and as a reminder of the meeting.

The minimum standards for approval, enumerated before, must be adhered to before approval can be given This is not as difficult as it would Most of the hospitals possess the necessary personnel to organize a tumor clinic is an urgent need for competent pathologists in New York State, but some communities have solved this problem by having one pathologist service an entire county The county health laboratory and its pathologic service have many advantages The pathologist, too, can benefit by such consul-At times it would be the means of rendtation ering a more accurate diagnosis When more pathologists can be procured, every hospital or community should attempt to obtain such service The personnel of a clinic, perhaps with the exception of the pathologist, is available in most hos-It is merely a matter of organization and bringing the staff members together to form While "clinic" is a word that numerous physicians have come to fear and dislike, the tumor clinic can aid the physician and the hospital by rendering the cancer patient better facilities for diagnosis and treatment

The purpose of the cancer clinic is to insure better care for cancer patients. Cancer is believed by some to be the nation's foremost public health problem. The incidence of cancer is increasing, and every community should be prepared to render adequate service to these patients, not only to the patient with early disease, but also to those with advanced cases. There are always a certain number of the latter who do not receive adequate care. Such care can be provided in the home, hospital, or nursing home.

The tumor clinic will provide consultation by those well versed in the various methods of diagnosis and treatment. In the beginning, per haps, a consultant, qualified in the diagnosis and treatment of cancer, can be brought to the clinic. However, this arrangement can be a detriment as well as an aid to a tumor clinic Patients from the community in which the tumor clinic is conducted may ignore the local facilities and go to the consultant soffice or hospital for ding nosis and treatment. This has actually occurred and caused friction between the staff of the tumor clinic and the consultant As a rule after a consultant has regularly attended a clime for two or three years such service is no longer necessary If his services are still required the consultant is not a good teacher or the staff members are reluctant to become interested and assume their rightful responsibility

The staff of the tumor clinic will constitute a definite organization of members selected for their ability in the various specialties of medicine and will provide a continuity of service for the cancer patient. This will serve as a means of providing postgraduate facilities in the study of cancer to the members of the staff. The diag nosis made by the tumor clinic group will be more accurate because in most instances it will be based on pathologic findings. Then too the given condition can be discussed freely from a pathologic surgical and radiologic point of view with an evaluation of the ment of various types of therapy at the disposal of the members of the clinic

Follow up of the patient is very important is generally conceded that the clinic patient has better follow-up than does the private patient The reasons for this are obvious to all of us who have practiced private medicine The follow-up service can be provided in the tumor clinic by a staff familiar with the cancer problem follow-up examination should not be a cursory one, rather the tumor clime group should be prepared to seek and recognize metastatic foci at sites of predilection This could be accomplished not only by physical examination but also by diagnostic x ray and laboratory tests Often these facilities are not available in a physician s office, and if the physician was not interested and cognizant of the behavior of the various types of malignancy with which he is confronted he might fail to recognize the extension of the cancer to organs nearby or to those more distant

In the chaic a planned program for therapy could be carried out and the various methods of therapy could be properly evaluated. This could take the form of clinical research including a record of the types of manganancies seen at the clinic and how these responded to therapy. Fur

thermore, the clinic staff would have the opportunity of noting whether the patients are suffering from late or early disease. This could have a direct bearing on the educational program which was necessary for the given community

To be more specific, the tumor clinic is benefi cial to the patient physician and hospital tients, as a rule, refrain from leaving their own com munity for medical services, but many hospitals and physicians force patients to go elsewhere because of lack of facilities, fashion, and personal prejudices The tumor clinic will provide adequate facilities for diagnosis and treatment, and if, in the given clinic, the facilities are not adequate, these can always be supplemented The average patient has a great deal of confidence in his personal physician. his visits are awaited with a great deal of anticipation his advice is always engerly sought when cancer is encountered the patient is receiving care in his own community, that patient-physician relationship is not disturbed However if the patient is sent to another community for treatment, it is impaired The family physician can aid the specialist in the care of the patient by assuming some of the responsibility and by reassuring the patient about the treatment which is being given. The patient receiving follow-up treatment and observation is more apt to keep the appointments, due to the proximity of the clinic This will be more condu cive to the immediate detection of metastases or recurrences and more effective palliative treatment will be afforded the patient all of which will result in longer life and a longer period of useful economic activity

Through the tumor clinic the physician can aid in the diagnosis and outlining of treatment for the patient and observe and care for him while treatment is being given. The patient remains under his direct supervision and control. It also affords the physician an opportunity to participate in postgraduate cancer education by observing groups of cancer patients at the tumor clinic Better records are kept by the physician concern mighis cancer patients. Clinical research will be correlated with laboratory research. By pooling the knowledge of the tumor clinic group, more accurate diagnosis and better therapy will be instituted.

Once a tumor clime has been established in a hospital, that hospital is reluctant to discontinue this activity. It completes the service rendered by the hospital to the community. The clinic will be the means of increasing the number of hospital days, it will be directly responsible for in creased case load in the x-ray diagnostic x ray therapeutic, surgical, and laboratory departments. It may seem as a casual observation, that the tumor clinic is a liability, but upon close

scrutiny and evaluation of all of its advantages to the patient, the physician, and the hospital it is seen to be a definite asset

The tumor clinic program in the State of New York has become more effective, since the staff members of the respective tumor clinics have organized the Tumor Clinic Association of New York State Regular meetings and clinics are held to aid in the conduct and operation of the clinics in rural communities as well as in the large Such collaboration and exchange of hospitals ideas has improved the tumor clinic service. This organization is interested in every type of problem confronting tumor clinics and has done much toward formulating policies to govern the conduct and activity of these clinics

Aid in the operation of the tumor clinic can come from many sources Some hospitals have assumed full responsibility for the clinic, even going so far as to assume the entire cost of diagnosis and treatment of the indigent patient when the payment for these services cannot be obtained from other sources The Department of Welfare will aid in defraying the expense incurred by the The private patient indigent cancer patient will pay for tumor clinic service, since he expects to pay for this service as he does for any other hospital service The remuneration obtained from patients may not be sufficient to defray all expenses The New York State Department of Health through the Division of Cancer Control will furnish secretarial aid to a clinic This is a part-time position and the work of the clinic is performed outside of regular duties secretary will receive 40 cents an hour and will be limited to forty-eight hours a month proved sufficient for most clinics Funds for other secretarial service for special projects are also available

Clinical aid for the medical preparation of patients for presentation at the tumor clinic can also be arranged This is usually granted to a resident or to a young physician who is interested in The physician for this service the tumor clinic is chosen by the staff and is under the jurisdiction of the tumor clinic staff The compensation paid for these services is \$10 per clinic session

The federal government has allotted New York State a sum of \$219,000 for cancer control These funds can be used for radium for loan to tumor clinics and also for the payment of consultants for tumor clinics The fee has been placed at \$50 per day plus traveling expenses Provisions have been made for clinical and nursing aid in cancer detection clinics and also for one to three months postgraduate training for physicians in various phases of the cancer problem

The American Cancer Society through the New York State Division also grants funds to aid

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tumor clinics in New York State To date. projects totalling \$248,791 88 have been financed by this organization to various hospitals through-These funds can be used either for out the state a service or an educational program Funds have been granted for the purchase of diagnostic and therapeutic equipment, as well as for the purpose of providing physicians an opportunity for postgraduate study at other recognized clinics A study is also being made of the cost of caring for advanced cancer patients This is a costly procedure and only limited funds can be supplied for this purpose, but it is being tried out as an expen-

Any tumor clinic which is desirous of receiving funds from the American Cancer Society must have the project approved by the Cancer Committee of the local county medical society request is then submitted to the office of the American Cancer Society, New York State Division, Inc., Terminal Building, Rochester, New The nature of the project will determine its referral to the service or the educational com-After careful study by either of these committees, it is approved or disapproved as the ments of the project indicate. If it is disapproved, the reasons are given, and when the project is returned, recommendations are made concerning the faults of the project. On the other hand, if it is approved, it is presented to the executive committee which confirms the project, and the money is granted This procedure does not consume much time, but all these projects must be studied carefully and granted through their own merits, since this money was contributed by the people of the State of New York voluntarily for the control of cancer All of this money must be put to the use of the cancer patient, our chief concern

The Roswell Park Memorial Institute, which is the New York State Cancer Hospital, has an important role in the tumor clinic program of the At its last meeting the Tumor Clinic Association designated the Institute as the "mother clime" The staff of the Institute has accepted this responsibility

There is need for a state cancer hospital and also for the tumor clinics The Institute should be and is prepared to care for patients who cannot receive care at the local tumor clinic cancer patients cannot be treated at the local clinic, but the local clinic should have some institution where necessary diagnosis and treatment are available to which the patient can be referred Forty-five per cent of the patients referred to the Institute have benign disease These should all be diagnosed and treated in the community in which these patients reside This would relieve the case load of the Institute and allow more

time for the cancer patient Physicians should know their limitations, if a cancer patient cannot be treated at a given clinic, the patient should be referred to the Institute or some other clinic where suitable treatment can be given staff members of some clinics are unable to per form difficult and prolonged surgery required for the complete removal of cancer of the mouth. esophagus, atomach, chest, larynx, bowel, etc At times these patients are not afforded the opportunity of this surgical treatment, because it cannot be obtained at the local clinic Institute is able to furnish this service, and that is one of its important roles. If a patient upon laparotomy, is found to have a malignancy beyoud the skill of the operator that patient should be sent to the Institute or elsewhere in order that the patient may be given the advantage of a more experienced or skillful surgeon The same applies to radiation. The application of radiation is an exacting science. Therapeutic v ray is a potent therapeutic agent, its use must not only be understood but properly applied \(\strace{1}{3} \) ray therapy at times has come into disrepute because of improper application. A 200 kilovolt machine will not be suitable for all types of malignancies The x ray therapeutist should not only recognize his own limitations but also the limitations of his x ray machine. The 200 kilovolt machine has a rightful place in the therapeutic armamentarium but alone it is not entirely sufficient. Many pa tients require treatment with higher voltages in order to apply homogeneous radiation to the cancer If the higher voltages are indicated and not available, that patient should be sent to a clinic where such treatment is available. The same holds true for radium therapy In order to have a successful tumor clinic program in New York State the Institute must work with the tumor climes prepared to supplement services which cannot be obtained in the local clinics The Institute, through its reorganisation and aug mented program, is able and ready to give these services. Lack of beds at the Institute is hinder ing our program at present, but it is hoped that in the future a new hospital will afford more beds for cancer patients.

The responsibility of offering treatment to approximately 37 000 cancer patients in upstate New York is the responsibility of the Medical Society of the State of New York, the Tumor Clinic Association, the New York State Department of Health and the American Cancer Society, New York State Division

Summary

1 The minimum standards for tumor clinics as adopted by the American College of Surgeons are commercted

- 2 There are 407 fully approved tumor clinics in the United States
- 3 New York State, exclusive of New York City, has 41 tumor clinics, 34 of which are approved
- 4 A definite distinction exists between a tumor clinic and a detection or preventive clinic
- 5 The organization operation, and purpose of a tumor clinic are discussed
- 6 The benefits of such a clime to the physician, to the hospital, and to the patient are enumerated
- 7 The program of the Tumor Clinic Association is integrated with that of the Roswell Park Memorial Institute
- 8 Tumor clinics and physicians have limitations regarding the diagnosis and treatment of cancer patients. These must be recognized

633 NORTH OAK STREET

Discussion

Archibald S. Dean, M.D., Buffalo —Dr. Kress has presented a comprobensive and dynamic summary of the status of tumor clinics in New York State. The medical profession has made remarkable progress ance 1930 in the development of tumor clinics, but the high incidence of cancer calls for greater utilization of such facilities.

Public health administrators are becoming increasingly concerned with the control of cancer. The development of county health departments and of the health services of large cities with State aid will provide more administrative and public health nursing personnel to assist in the campaign for the early diagnosis and adequate treatment of malignancies.

The minimum standards of the American College of Surgeons for tumor clinics as given by Dr Kress, state that a social worker shall be available for the purposes of the clinic and that patients shall receive periodic examination for a period of at least five years following treatment

Social workers in the Buffalo region are not generally available for home calls outside the munici palities in which the tumor clinics are located Public health nurses however serve the rural as well as the urban area. Tumor clinic patients who fail to return for the completion of diagnosis or therapy after letters have been sent to them should be referred to public health organizations for visitation by public health nurses. The nurse sometimes finds that the patient is too ill to get to the clinic Various hindrances to clinic attendance may be met and solved by the public health nurse who makes the home visit. Dressings and other care and instruction when necessary can be given to the cancer patient at home when there are sufficient public health or visiting nurses

When other measures for porsuading tumor cluic patients to return for periodic examination following treatment, have been exhausted, public health nurses in localities adequately supplied with per sonnel may assist by usiting the patient in his home The extent of such service will depend upon the wishes of the tumor clinic staff and the comprehensiveness of the local public health organization Dr Holla, Westchester County Commissioner of Health, has informed me that his county public health nurses make many home calls to tumor clinic patients before and after treatment

The State district and local health services which maintain rosters of reported cancer patients receive monthly from the State Division of Cancer Control a list of persons who have died of cancer Each tumor clinic may receive each month from the district or full-time local health officer a list of the deaths of persons who were reported as cancer patients by the tumor clinic The report to the tumor clinic includes the name and address of the person, the date of death and the primary and secondary causes of death by code numbers The tumor clinic physicians appreciate this service from health officers

Kress has differentiated between tumor clinics and the so-called cancer prevention or cancer detection clinics to which persons without symptoms of neoplastic disease may go periodically for examination The primary objective of the cancer detection center is to detect sooner than would otherwise be discovered, early cancer, precancerous lesions, or areas of chronic irritation which may be followed by cancer

The American Cancer Society stated in March that whereas only 15 cancer detection centers were reported in operation in the United States last year, there are now 118 The American Medical Association has approved of the cancer detection center standards of the American Cancer Society, while the American College of Surgeons has announced plans for a nationwide survey and approval of cancer de-The Maryland State Department tection centers of Health and the Maryland Division of the American Cancer Society, jointly, with the cooperation of medical societies and local health departments have recently established cancer prevention centers

Health officers generally are convinced that x-raying the chests of all supposedly well adults is an effective way of discovering tuberculosis early cidentally, the x-raying with 70-mm film of the chests of 85,000 persons by the Buffalo and Erre County Tuberculosis Association during the past year disclosed that 42 persons-or 1 among each 2,000 x-rayed—had suspected neoplasm in the chest

Public health officials may well cooperate with the rest of the medical profession in supporting tumor diagnostic and treatment clinics and in evolving various acceptable plans for lessening the time interval between the development and the discovery of cancer

Morton L Levin, M.D., Albany — The tumor clinic as a means of improving community facilities

for meeting the clinical problems of cancer has, from its inception, had the firm support of the American Medical Association, the American College of Surgeons, and the Medical Society of the State of New York Since the tumor clinic is a specialized form of group practice, cancer is the first major disease recognized by the profession as requiring some form of group practice to secure the fullest application of medical science Under the leadership of James Ewing in 1939, the New York State Legislative Cancer Commission recommended the establishment of more tumor clinics in this state as the preferable alternative to the creation of specialized cancer hospitals Thus, as a test of the soundness of that recommendation, the tumor clinic has been, and still is, on trial as a method of meeting the needs of cancer patients

At present approximately 15 per cent of new cancer patients are referred to tumor clinics in the upstate area How well each clinic meets the demands upon it depends on the quality and training of its staff and the support which it receives from the other physicians of its hospital and community These factors vary considerably It should be noted, however, that regardless of its initial value, the tumor clinic acts as a constant educational experience for its staff and for those physicians who attend its meetings Thus, their proficiency in meeting the special problems of cancer patients increases faster than if they relied solely on their own practices for such experience In some instances the teaching value of the clinic is increased by the regular attendance of a consultant, usually a graduate fellow of a recognized cancer center Although not many such consultants are now available in the upstate area, in the next few years their number will probably increase

There is little doubt that a well-organized, properly staffed, and fully supported tumor clinic is a medical facility valuable to the hospital and the community Whether tumor clinics alone can meet the full demands of the general practitioner for consultation and assistance in providing the most modern technics of diagnosis and therapy for malignant tumors remains to be seen One of the factors which will influence the result is the extent to which tumor clinics receive the full support of the practitioners of the community

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PENICILLIN IN GONORRHEA

Experiences with Various Preparations and Technics

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(From the Social Hygiene Clinics Department of Health and Public Health Research Instituts of the City of New York Inc.)

THE pencillm therapy of generatea, in the period when penicilin was a restricted commodity, was limited originally to patients restrant to sulfonamide treatment ¹ A varying number of injections of pencillin dissolved in water, were given every two or three hours. This particular treatment required hospitalization of the patient according to our knowledge at the

A practical ambulatory method of treatment was introduced in the venereal disease chines of the New York City Health Department in August, 1944 using an aqueous solution of penicil lin administered by intramuscular injection every two hours for three injections. Our ambulatory methods of treatment date from this time

Type of Patients—The ages of patients ranged from eleven to sixty years—They were of many nationalities and of both sexes—All stages of genoeoccic infections from acute to chronic were included and treated by the same technic

Diagnosis—The diagnosis was based on the positive bacteriologic findings in smear and culture of the discharges. The culture medium employed in our laboratory is that devised by Peiser.

A serologic test for syphilis was performed on all patients on admission. Where the test was negative, it was repeated every month for three months. We have encountered no instance of a masked syphilitic infection in a patient treated for gonorrhea with penicillin.

Criteria of Cure—No patient was considered cured for purposes of this study until clinical symptoms had disappeared and until three suc cessive smears and cultures, taken at weekly intervals from the urethra and prostate in the men patients and from the urethra and cervix in the women patients were negative Patients who were not observed long enough to meet these criteria were eliminated from the final evaluation of this form of therapy

Treatment

In the evolution of penicillin therapies a single injection method, using first a water-in-oil emul

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sion and, subsequently an oily mixture, was employed originally Later, several preparations of penicilin administered orally were used Our experience with these different preparations and methods is herewith detailed (Table 1)

TABLE 1 -PENICULIN IN GONORRHUA

	Dosage	Number Treated		Per Cent Cured	
Type and Method	Units	Men	И ошев	Men	Women
Aqueous solution					
3 doses	100 000	396	58	87	83
3 doses	150,000	075	178	86	88
1 does	150 000	101	16	71	75
Water-in-oll omul					
*ion					
1 dose	150 000	1 049	811	78	88 87
1 dose	200 000	1,326	484	80	87
Oily mixture					
1 dose	150 000	3 517	800	65	84 97
1 does	300,000	155	33	93	97
Oral—Tablets			_		
Plain	400 000	13	0	46	_0
Alum-Buffered	400 000	92	8	88	75
Lipoid-Buffered	400 000	46	G	76	100

Pencillin in Water—The first practical ambulatory method for treating patients with gonorrhea consisted of dissolving the required dosage of penicillin in 6 cc of water and injecting 2 cc of this solution intramuscularly in the gluteal region every two hours for 3 doses

Five hundred four patients were treated using 100 000 units of penicillin in water in 3 divided doses Of these, only 454 patients consisting of 306 men and 58 women could be followed and observed, 87 per cent of the men and 83 per cent of the women were cured

One thousand eighty-eight patients were treated using 150,000 units of penicillin in 3 divided doses. Of these, 853, comprising 675 men and 178 women were observed for the proper study period 86 per cent of the men and 88 per cent of the women were cured

One hundred seventeen cases were treated with 150 000 units of penicilin dissolved in 2 cc of water and injected intramuscularly in a single does. There were 101 men and 16 women. Seventy-one per cent of the men and 75 per cent of the women were cured.

Pencillin Envisions — The material was prepared by dissolving the required dose of pencillin in 14 ec. of water and emulsifying the solution in 31 ec of a mixture of 11 parts falba and 20 parts of peanut oil The total amount, 45 ec., was injected intramuscularly in the gluteal region. This method was first used in August 1945.

The doses of penicillin used and the results were as follows

- 1 Penicillin water-in-oil emulsion—150,000 units 2,986 patients were treated with this preparation. It was possible to follow 2,160 cases, 1,649 men and 511 women. Seventy-eight per cent of the men and 86 per cent of the women were cured.
- 2 Penicilin water-in-oil emulsion—200,000 units 2,467 patients were treated with this preparation, and 1,810 were followed for a sufficient period. There were 1,326 men and 484 women, 80 per cent of the men and 87 per cent of the women were cured.

Pencellin Oil Mixture — This preparation consisted of very finely ground pencellin thoroughly dispersed in a mixture of 11 parts falba and 20 parts of peanut oil. The treatment consisted of 1 intramuscular injection of the entire dose of pencellin in 1 cc of falba peanut oil mixture. The use of this preparation was begun in June, 1946.

- 1 Penicilin oil mixture—150,000 units 7,151 patients were treated with this dosage, and 4,409 of these were observed for a sufficient length of time for definite conclusions There were 3,517 men and 892 women, 65 per cent of the men and 84 per cent of the women were cured
- 2 Penicillin oil mixture—300,000 units 278 patients were treated with this dose, of whom 188 were observed for the proper study period. There were 155 men and 33 women, 93 per cent of the men and 97 per cent of the women were cured.

Oral Pencillin—Three preparations were evaluated The first was an alum-precipitated pencillin buffered with 0 3 Gm sodium benzoate The second was crystalline potassium pencillin G buffered with glycerides and sodium salts of fatty acids * The third was crystalline potassium pencillin G unbuffered * It was found that a minimum of 400,000 units, given in 4 divided doses every three hours, was required for oral use

Thirteen patients were treated with unbuffered crystalline potassium penicilin. Seven of these failed, and further use was discontinued

One hundred cases were treated with alum precipitated tablets There were 92 men and 8 women, 88 per cent of the men and 75 per cent of the women were cured

Fifty-two cases were treated with tablets of crystalline potassium penicillin G buffered with glycerides and sodium salts of fatty acids. There were 46 men and 6 women, 76 per cent of the men and 100 per cent of the women were cured.

Discussion

Patients who failed to be cured by any of the above methods of treatment were re-treated with the same preparation using double the dosage for the second course Re-treatment was, in some instances, necessary 3 or more times Failure of treatment was noted if the smears and cultures were postive within one week after treatment. Thus far we have failed to encounter any penicil-lin-resistant infections. The majority of the patients who failed to stay under observation for the required number of laboratory examinations were, in all likelihood, cured, since many of them had one or two post-treatment negative smears and cultures before being lost from observation.

Our first ambulatory treatment using 3 injections of penicillin aqueous solution every two hours resulted in from 83 to 88 per cent cures. Our next preparation, water-in-oil emulsion, gave practically a similar range of cures. However, an aqueous solution of penicillin, injected as a single dose, gave considerably fewer cures, 71 to 75 per cent. It is, therefore, evident that retardation of absorbtion by oil mixtures or repeated injections of water solutions give similar therapeutic results. The single injection of a preparation of penicillin in a retarding vehicle is a more practical ambulatory method.

Our first dosage level with water-in-oil emulsions was 150,000 units. This gave us from 78 to 86 per cent cures. Thinking that an increased dosage would increase the percentage of cures, we used 200,000 units. Our cure rate, however, was practically the same, between 80 and 87 per cent. Inasmuch as there was no greater therapeutic effect, we returned to our original dosage of 150,000 units.

When we employed a mixture of penicilin with an absorption retarding agent, eliminating the water, our early results, using 150,000-unit dosage, were approximately the same as those with emulsion or with water solution in repeated doses. Within the past year, cures with 150,000 units in this mixture became fewer and fewer. Therefore, we doubled the dose for the initial injection. The therapeutic results were greatly improved by this increase in dosage to 300,000 units, ranging around 88 per cent. We have, therefore, increased our dosage in routine clinic treatments to 300,000 units.

Summary

A series of 14,756 patients was treated with different forms of penicillin, 10,156 of these were followed long enough for conclusive evaluation Ambulatory treatment, yielding cure rates between 78 and 88 per cent, can be effected by injection of 3 divided doses of an aqueous solution of penicillin, or a single injection of penicillin incorporated in an absorption-retarding oily mixture or emulsion, or by oral administration of properly buffered penicillin tablets. For efficient medical

^{*} Supplied by Commercial Solvents Corporation

and public health control of genococcic infection, the best practical method of treatment is a single intramuscular injection of an oily mixture of 300 -000 units of penicillin

Discussion

Robert S Westphal, M D, Rochester — A few months after Dr Rosentinal and his associates started using an aqueous solution of penicillin every two hours for three injections the State Department of Health became aware of their procedure and it was promptly recommended for use in the clinics and by the physicians of upstate New York. We never had any cause to feel that the technic was not good for ambulatory treatment with penicillin in its stage of development at the time

I was particularly interested in the comment that they had encountered no case of masked syphilis in spite of the fact that over 10 000 patients were followed scrologically for a minimum of three months. On the basis of that information I would like to suggest that the VD control officer and nurses in the Rochester Health Bureau Clinic should discontinue this practice. If we can treat 10 000 cases without finding a masked infection our organization should be able to proceed for some time without finding any However, we will probably continue to follow them for fear of missing one. Perhaps in any event, they should be followed for a lumer period.

longer period. In trying to determine the therapeutic efficacy of a drug, it is my opinion that as many variables as possible should be climinated. The authors indicated that their criteria for cure were 8 successive negative films and cultures taken at weekly intervals Unless the New York City patients vary con siderably from the Rochester patients 1 or 2 rein fections could occur in that length of time and the cases might be considered treatment failures. I would prefer taking specimens for microscopic and cultural tests at intervals not longer than two days. This would tend to rule out the variable of repeated infection, and if the treatment is at all effective the laboratory tests should be negative in a few days at most. Furthermore it is much easier to persuade patients to return for tests for six days than it is for three weeks. Thus fewer patients would be lost by the wayside.

I note also that prostatic specimens were obtained from the men in determining cure Since using penicillin, I have felt this to be unnecessary because prostatitis has ceased to be a common complication This may be true because we see of gonorrhea nationts earlier in the course of the disease in fact we rarely see a patient for the first time as long as a week after onset. This opinion has been confirmed by an unpublished report of over 200 negro men treated with penicillin In the follow up examina tion of these patients 3 methods were used for obtaining specimens. The specimens were taken from prostatic secretion, urine sediment, and by inserting a small cotton swab approximately 1 inch into the In more than 200 patients there was no instance of a positive film or culture from the prostatic accretion or uring sediment when the swab method was not positive

You may be interested in a newer technic for ad ministering penicillin which has been tried recently in Rochester A Rochester physician devised a handmade penicillin blower which administers finely powdered penicillin in either powdered glucose or dry blood plasma. This is accomplished by blowing the mixture into the patient's mouth while he in hales deeply It is said that by this method the penicillin level in the blood is more than twice as high as when it is administered intramuscularly and. thirty-six hours after the one application, the blood level is still above that required for therapeutic effect. Of course, more work is required on this regime but it is a simple, cheap method and not un comfortable for the patient

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B VITAMINS AND FOOD UTILIZATION

Animal experiments have indicated that vitamin B complex deficiency interferes seriously with the intestinal absorption of glucose Such deficiency also causes marked loss of appetite and consequently of weight. A striking increase above normal was observed with respect to intestinal absorption of glucose food consumption, food utilization and weight gain in animals during recovery from such a deficiency with a vitamin B complex supplement. No one individual component of the B complex was found to be alone responsible for these effects.

Thiamin was found to have the greatest influence on the digestive functions of the body during recovery Pantothenic acid and riboflavin were less of fective. Pyridoxine seemed to be least effective. The investigators stress the importance of the vitamin B complex in the nutritional rehabilitation of war stricken populations. They point out that since the B vitamins increase the efficiency of food utilization the effect is virtually that of augmenting available food sources—Borden a Review of Nutrition Research January 1948

CHRONIC BENIGN PNEUMONITIS

Its Discovery in Older Individuals with Diminished or Absent Gag Reflex

Louis Schneider, MD, Mt Vernon, New York

(From the Chest Clinic, Washington Heights Health Center)

TERY wisely, chest x-ray surveys of the apparently healthy population are being done in increasing numbers and frequency Thus, more and more of the older age groups are being This group will come also into roentgen focus as a result of the drive to perform routine x-rays upon admission to general hospitals quite natural that among these older people, some by-products of tuberculosis case-finding will cause the examiner a good deal of concern refer particularly to the discovery of persistent basal pulmonary infiltrations on the routine chest film, unaccompanied by symptoms referable to the lower respiratory tract Even before chest surveys became a common procedure, such lesions have frequently been interpreted as representing bronchopulmonary neoplasm With the emphasis on early surgical eradication of such new growths, and with the perfection of lung surgery technic, such individuals have been and may continue to be subjected to needless lobectomy and pneumonectomy 12

It is for the purpose of emphasizing the importance of careful assay of asymptomatic basal pulmonary pathology, as disclosed by \-ray, that the following two cases are reported proof of the diagnosis is not available because of the reluctance on the part of these healthy men to undergo the necessary confirmatory tests The writer would have liked to obtain bronchoscopic examination and even aspiration biopsy to prove that we are dealing here with chronic benign aspiration pneumonitis 34 In the absence of socalled characteristic sputum findings, the careful case history, physical examination, and \ray appearance of the lesions, taken together, made up the diagnosis which apparently has been confirmed by the observation of time

Case Reports

Case 1—H S, a sixty-two-year-old white man, a native of Italy who had lived in this country forty-four years, was a retired realtor, living in financial comfort. His family history was negative as well as his past history, except for longstanding postnasal drip and large left hydrocele.

As a result of a case-finding \-ray in his community, a phthisiologist ordered this man into the hospital with a diagnosis of "atelectasis due to new growth or unresolved pneumonia" He appeared at our clinic for the first time on August 13, 1946, protesting against this recommendation with which his bewildered family had anxiously concurred

On admission to the clinic, he insisted that he felt as well as ever except for the slight discomfort due to the hydrocele—Physical examination revealed a well-nourished, well-preserved individual who looked younger than the stated years—Temperature, pulse, and respiration were normal—The following pertinent data were recorded—There were no remarkable throat findings—The heart was negative. The lungs were entirely clear—There was no clubbing of the fingers—There was a left hydrocele the size of a large orange.

The first chest x-ray was taken on April 30, 1946, and showed the same abnormal shadows as seen in the celluloid reproduction of June 17, 1946 (Figs 1 Here we see a large, dense, ground glass lesion, confined to the right middle lobe, and a small irregular patch of hard density above the left mid diaphragm Sputum, obtained with difficulty, was negative for acid-fast bacilli The blood count showed a slight secondary anemia It occurred to us that this might be a case of nonsymptomatic oil aspiration pneumonitis Careful questioning revealed that he had been taking mineral oil for con stipation for the past twenty years He was in the habit of drinking this product directly out of the bottle, ingesting several tablespoonsfuls nightly and sometimes during the day Hardly a day passed without his taking about two ounces of the hydrocar



Fig 1 The film taken June 17, 1946, shows a large patch of ground-glass density adjacent to the right heart border and a smaller patch above the left diaphragm. The bilaterality of the basal lesion led to the suspicion of mineral oil-aspiration pneu monitis rather than bronchial neoplasm.



Fig. 2. An oblique view showing the lesion to be predominantly in the right middle lobe



Fig. 3. The film taken eleven months after the first x-ray showing no change in the extent or character of the basal process

bon Re-examination of the throat revealed almost complete absence of the gag roflex The patient was otherwise neurologically negative.

In order to allay apprehension the patient was advised that the pulmonary findings were not due to malignancy but were the result of his laxative-taking habit. He was advised to switch to pills for bowel control. Unfortunately he could not be convinced of the necessity for bronchoscopic examination or a lung aspiration biopsy to confirm our clinic impression. The sputum submitted did not show the presence of mineral oil by the usually recommended tests 1 With some coaxing, he was seen on a few occasions after the first visit the last examination being made on March 27 1947 After almost a year of observation, he has remained as well as ever has even gained some weight and has had no intercurrent illnesses Eleven-month serial film follow-up shows no change in the appearance or extent of the basal lesions as originally seen (Fig. 3)

Case ! — E. O a white man, aged forty nine was born in the United States of Norwegian extraction. Both family and past history were negative.

This man is in good health. On December 21 1946, a pre-employment chest x-ray revealed a right basal lesion. He was sent to our clinic for an opin ion regarding these lung findings and was admitted for observation on February 10 1947 He denied any symptoms whatever at that time and revealed no remarkable findings on physical examination. The lungs were entirely clear and there was no clubbing of the fingers. A ray of the chest on admission revealed a small patch of increased density adja cent to the right lower lung root this was unchanged in extent or character from the area seen on the chest film taken three months earlier Further questioning on his reappearance at the clinic disclosed that this individual has for the past four years been equiring neosynephrine hydrochloride jelly (water

soluble) into his nostrils twice daily. This procedure would often be followed by a coughing and hawking spell as the preparation entered his throat Examination of the throat revealed a complete absence of the gag refiex. The patient has remained well for almost six months of observation, and during this period all films have shown a stationary right basal lesion (Fig. 4). He was however ordered to discontinue the use of nasal medicaments



Fig. 4. This film shows a small patch of increased density in right lower lung field the lealen discovered on routine survey of a man habituated to the use of nasal Jelly. The patient has no symptoms referable to the lungs and the process has remained stationary during six months of x ray observation.

Comment

The extension of tuberculosis case-finding surveys makes it timely to call attention again to the phenomenon of chronic aspiration pneumonitis and especially to emphasize its frequently asymptomatic and benign charac-Most adult cases reported have been patients in hospitals for chronic diseases or for the aged, and have been debilitated individuals or those having dysphagia due to an organic neurologic condition such as multiple sclerosis or hemiplegia 5 The fact that this condition can be found in healthy persons, however, must always be borne in mind upon seeing silent basal lesions on x-ray film Then the examiner should embark on a searching inquiry not only concerning the repeated use of nasal medicaments, but also concerning the longstanding habit of taking mineral oil for laxative purposes It has been shown that even in the presence of a good gag reflex, some of the latter substance may run into the larynx because it fails to arouse that reflex properly

Cooper showed long ago that the experimental disposition of aspirated material is dependent entirely on gravity and inspiration suction 6 The location of this material is patchy and shows a tendency toward immediate aspiration into the Accordingly, we would expect to see benign aspiration pneumonitis, as discovered on survey films, almost always confined to the right middle or lower lobes In a state of more or less extended recumbency, as with chronic hospital cases, it is not surprising to see aspiration pneumonitis in the upper lobes as well 5

From the clinical-roentgen viewpoint, differential diagnosis of this condition should not be very Bronchiectasis withsuperimposed pneumonitis may be ruled out by the paucity or absence of physical signs and symptoms and by the absence of clubbing Active basal pulmonary tuberculosis does not give such an x-ray picture, as a rule, and will not remain stationary on serial follow-up, the absence of tubercle bacilli in sputum and gastric contents in the presence of such pathology also speaks against tuberculosis We bear in mind, however, that pulmonary tuberculosis, apical or basal, may occasionally be as much as moderately advanced on x-ray and yet give no respiratory or other symptoms

The most important differential diagnosis to make is from neoplasm As is well known, early diagnosis of primary bronchial new growth is essential to its effective surgical eradication Here the combination of history, lack of symptoms, and paucity of any chest signs in the presence of basal involvement, point more to aspiration pneumonitis than to tumor Radiologically. the finding of illdefined, dense, ground-glass infiltration, as seen in the first case, speaks more for the benign pathology under discussion, its bilaterality also speaks against new growth course, one cannot take a "wait-and-see" attitude, as was necessary in these cases, letting time rule out the possibility of the presence of neo-

Hence, when there is the slightest doubt about the diagnosis, a thorough study is indicated, including bronchoscopy, sputum examinations, and even aspiration biopsy, so that bronchial neoplasm may be diagnosed at the earliest operable stage

Summary

- Two cases of asymptomatic benign aspiration pneumonitis in older individuals are reported
- The diagnosis has been confirmed circumstantially by the observation of time
- The clinical-roentgen character of this disease is emphasized
- Its differential diagnosis from bronchial neoplasm is considered most important
- It is expected that more and more of these cases will be found-if properly diagnosed-as chest x-ray surveys proceed a pace

311 SOUTH THIRD AVENUE

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ANNOUNCE OPHTHALMOLOGY EXAMINATIONS

The American Board of Ophthalmology has announced that the 1948 practical examinations will be held in Baltimore, Maryland, from May 20 to 25, and in Chicago, Illinois, from October 6 to 9

Written qualifying tests will be held annually, probably in January of each year Applications for the January, 1949, written qualifying test must be filed with the secretary before July 1, 1948

Officers for 1948 are Dr Everett L Goar, Houston, Texas, chairman, Dr John H Dunnington, New York City, vice-chairman, and Dr S Judd Beach, Portland, Maine, secretary-treasurer All communications should be addressed to the American Board of Ophthalmology, Cape Cottage, Maine

THE ROLE OF CHOLINE CHLORIDE IN THE TREATMENT OF CERTAIN CASES OF DIABETES MELLITUS

Studies of Liver Dysfunction-I

Louis Pelner, M.D., Benjamin Davidson, M.D., Samuel Waldman, M.D., and Robert Margolis M.D. Brooklyn, New York

A LTHOUGH the liver plays a basic role in carbohydrate metabolism it has been neg lected in the management of the diabetic patient until very recently

Soskin and his coworkers stressed the importance of the liver in carbohydrate metabolism 1 They showed that (1) if depanceratized animals received a constant intravenous injection of insulin, just sufficient to maintain normal blood sugar administration of additional carbohydrate yields normal glucose tolerance curves, (2) if hepatectomised animals with intact pancreas are given a constant intravenous infusion of glucose just sufficient to maintain normal blood sugar ad ministration of additional glucose yields diabetic glucose tolerance curves, (3) when the liver is damaged by hepatotoxic agents, a diabetic type of glucose tolerance curve is obtained this experimental work it seems logical to deduct that the liver is of primary importance in carbohydrate metabolism

Biskind and Schreier pioneered in the treatment of diabetes by methods which apparently improved liver function ² Diabetes has been treated during the past twenty five years in terms of insulin deficiency. Biskind and Schreier suggested another possibility that because of liver damage the patient may not be able to respond to his endogenous insulin. Thus, the treatment may be carried out in 2 possible ways, by giving the patient exogenous insulin or by attempting to restore liver function. This may be possible in only certain cases of diabetes.

Many clinicians have long realised that there are two kinds of diabetes. One type of patient develops acideais easily, and another type goes along for years without attention to his diet spills fairly large amounts of sugar, and remains in comparative good health. The first type may be due to actual insulin deficiency and the latter type may be due to hepatic insufficiency.

Biskind and Schreier have used large doses of vitamin B complex from liver and from synthetic sources? The vitamin B factors included this min, riboflavin, niacinamide pyridovine, calcium pantothenate choline, inositol, and folic acid Good results have been obtained by this method of treatment, but these usually become evident

after an extended period of time. It appears that with such a large number of therapeutic factors to be given, it is difficult to administer a sufficient quantity of the active factor.

Two of our patients who responded later to choline by mouth were given three to four injections a week of vitamin B complex without effect. This therapy included enormous quantities of thiamin, riboflavin, niaconamide, pyridoxine, and calcium pantothenate but did not include choline chiloride.

We feel that the active principle in the B complex therapy of Biskind and Schreier is choline and this article is a preliminary report on the use of potent quantities of choline in some cases of diabetes mellitus

Fatty liver is a rather frequent finding in pa tients with diabetes Deparcreatized dogs, treated with insulin, often develop large, yellow, fatty livers.3 This condition could be prevented by the inclusion of raw beef pancreas in the diet. Later, it was shown that legithin was just as effective, and it was finally proved that the active constituent that prevents fatty liver in depan creatized dogs was choline. Casein was also shown to have hpotropic activity, which was demonstrated to be due to the methionine con Methionine acts by supplying methyl groups for the synthesis of choline.4 Experi mentally, other vitamin B factors besides choline were ineffective in preventing fatty liver or cirrhosis of the liver in animals

It was difficult to determine beforehand which cases would respond and which would not respond to choline. The usual liver function tests were not helpful. Results were usually obtained in middle-aged individuals whose diabetes had existed for only a few years. However, we have several young diabetics who responded well.

Four Gm of choline were given each day One Gm was dissolved in 1 dram of water and administered by mouth four times a day. If the treatment was successful improvement was usually noticed within two weeks. The blood sugar level fell, the patient gained weight and there was a marked improvement in well-being. If the patient was on insulin therapy, coincidentally, the insulin desage was reduced and finally eliminated entirely. Some of the patients have now been on choline for the past six months with salutary effect on the carbohydrate metabolism and with-

Presented before the Eastern Section of the American Pederation for Clinical Research, New York City December 14 1945.

out ill effects on the body The diet used in this treatment was liberal, consisting usually of 250 Gm of carbohydrates, 95 Gm of protein, and 75 Gm of fat (2,055 calories per day)

Eighteen diabetic patients were successfully treated, while eight did not respond to the medication. Some very spectacular results were seen

Case Reports

Case 1—A 50-year-old male with recent development of diabetes, loss of weight, weakness, a blood sugar of 345 mg per 100 cc of blood, and 2 per cent sugar in the urine responded to 4 Gm of choline per day. Within two weeks the blood sugar fell to 180 mg per 100 cc of blood, and the urine became sugar free, although the diet described above was administered. Subsequently, the blood sugar fell and continued normal on the same regime over a period of six months. The patient feels well and has gained weight.

Case 2—A 25-year-old man who had diabetes for eight years and whose mother is also a diabetic was taking 25 units of protamine zinc insulin daily. In spite of this, the blood sugar hovered around 200 mg per 100 cc of blood. Following the institution of this regime, the blood sugar fell to normal on the same dosage of insulin, and subsequently stayed normal, even though the insulin was discontinued entirely.

Case 3—A 59-year-old female had lost a great deal of weight over a period of two years. The urine showed 2 per cent sugar and the blood sugar level was 200 mg per 100 cc of blood. For more than one year she was given 18 capsules a day of a formula exactly like that used by Biskind and Schreier.

Each capsule contained 5 mg of choline chloride besides other vitamin B factors. Her blood sugar level was constantly around 160 mg per 100 cc of blood, although subjectively she felt markedly improved. The capsules were discontinued, and for a two-week period choline chloride was administered, 4 Gm daily by mouth. Her blood sugar fell to 120 mg per 100 cc of blood.

Other cases, equally dramatic, were studied We want to emphasize that choline chloride is not a substitute for insulin but has been of aid in the management of certain cases of diabetes. A method for selecting cases which might respond would be of aid, but so far none is available. It was noted that some of the patients who were benefited greatly have cholesterol deposits around their eyes. Perhaps those diabetics with a high blood cholesterol may be the best subjects for a trial with choline chloride. Other vitamins should be included in the therapy, because diabetic patients are often markedly deficient.

1352 CARROLL STREET 1457 UNION STREET 1661 PROSPECT PLACE 546 LAFAYETTE AVENUE

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ANNOUNCEMENT

1948 Medical Directory Deadline

All material for the 1948 Medical Directory of New York, New Jersey and Connecticut should be in the office of the Medical Society of the State of New York before April 15, 1948

No corrections or additions may be made after that date

PRIMARY FACE PRESENTATION

SIMON BRODY M D Brooklyn, New York

HYPEREXTENSION of the head before the onset of labor is very rare. Usually this condition occurs after labor has set in resulting either in a brow or face presentation DeLee states, 'As a rule, face presentations are fully developed only after labor has been fully in progress for some But in four cases I distinctly felt the full face lying over the inlet in the last month of preg nancy " According to Beck, Trimary face presen tations are extremely rare and in practice the possi bility of its occurrence is disregarded. The author has seen but one instance of face presentation before the onset of labor, the diagnosis of which he was able to confirm by x ray In that case spontaneous flexion occurred when the patient went into labor and the child was born as a vertex,

The report presented here is of interest since it was a case of hyperextension of the head, recognized about five weeks prior to delivery and confirmed by x ray findings. It also poses the problem of the management of such a complication.

Case Report

P 8, a 25-year-old white primigravida, was first seen in consultation on December 11, 1946. Het last menstrual period was on January 4, 1940. The expected date of delivery was November 7, 1946. Her past personal history was of no special significance. She started to menstruate at the age of thir teen every twenty four to thirty days the periods lasting four to five days. The prenatal course was uneventful. 2-ray examination on November 8, 1940 (Fig. 1) showed a face presentation at the infet



Fig 1 Face presentation as shown by x-ray on November 8 1046

According to the measurements there was a slight disproportion between the head and pelvis. In the opinion of the roentgenologist, spontaneous deliving might ensue, should the head come through in its shortest diameter. A test of labor was advised.

On December 11 the patient was still up and about. Fetal heart sounds were of good quality Membranes were intact and the patient had no complaints. Her urine was essentially negative Blood pressure was 112/80. Her blood was Rh positive type A.

Another v ray study of the pelvis was made according to the Caldwell and Molloy method (Figs. 2 and 8) Examination of the abdomen showed a single fetus with the face presenting. The fetal spine lay to the maternal left side and the face was seen on the right side of the pelvic inlet. The head was markedly overextended. The pelvis showed a fairly good inlet predominantly of a gonecoid configuration with a true conjugate of 13 4 cm. and the widest transverse diameter of 112 cm. The posterior saggital measurement at the inlet was 5 cm, at the midpelvio plane it was 5 cm. The bisschild diameter was 9 cm. Under normal circumstances, with a presentation of a more ordinary variety delivery from below could be accomplished. However with the face presentation noted above, delivery from below might be dangerous for the fetus.

Considering the fact that the patient was definitely postmature, with some cophalopelvic disproportion and extreme hyperextension of the headfurther delay seemed inadvisable and it was decided

to deliver her by section

On December 12, a low flap cesarean section was performed at the Crown Heights Hospital under fractional spinal anesthesia. Upon opening the uterus, the amniotic fluid was found to be meconiumstained A baby boy was delivered without any difficulty. He weighed 8 pounds 14 ounces, and was livid. The skin was meconium-stained. There was delayed respiration and there was no er. The head remained hyperextended for some time and there was an indontation between the scapulac where the occipit was pressing against the spine After sucjoin of the traches and administration of oxygen, the baby began to breathe and cry but the respirations were irregular and the cry was feeble The baby was placed in an incubator and given supportive treatment. In spite of all efforts the unfant expired about twelve hours after delivery. An autops showed atelectass of both lungs and dilatation of the right ventricle.

The mother made an uneventful recovery and was discharged from the hospital on the ninth post operative day

The interesting feature of this case is the existence of a face presentation for at least five weeks before delivery. By studying the baby a posture in utero as seen by the lateral view of the x-ray plate one can realize the extreme hyperextension of the head. Remaining in this abnormal posture for such a long period of time is probably injurious to the fetus. This was shown here by the meconium-stained amniotic fluid which was a sign of fetal embarrassment and the pulmonary atelectasis secondary to it

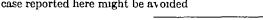


Lateral view of an x-ray, taken on December 11, 1946, showing a face presentation still present five weeks later

Posner and Buch, in a study of face and persistent brow presentation, showed that there was a higher incidence of maternal and fetal morbidity and mortality in cases of extension of the head? They advocated that cesarean section should be given greater consideration than heretofore, in cases in which face presentation is diagnosed early, especially in primipara

It would, therefore, seem advisable, in a case like the one presented here, when the condition is recognized early, not to procrastinate, but to deliver the baby by cesarean section as soon its viability is

In this way the danger of intrauterine embarrassment to the fetus by its long, abnormal position will be lessened, and the tragic consequences of the case reported here might be avoided



ONLY 5 PER CENT FAIL TO GET POLICIES Ninety-five out of 100 applicants for life insurance obtain policies, the Institute of Life Insurance reports This is indicated by an analysis of one year's applications of companies representing approximately one half of all ordinary life insurance purchased. The study, just concluded, shows that over 95 per cent of the applicants received policies, 85 per cent being standard rate policies and 10 per cent evtra rate policies

Fewer than 5 per cent did not secure the life insurance they applied for, and these failed to qualify



Detail of the plate, taken on December 11, showing the extreme hyperextension of the head

Summary

A case of primary face presentation, diagnosed by x-ray five weeks before delivery, is described patient was delivered by elective cesarean section The fetus suffered some intrauterine embarrassment as evidenced by meconium-stained amniotic fluid, in spite of the fact that the patient was not in labor and the membranes were intact Respirations were delayed and irregular, and the cry was feeble baby died at the end of twelve hours due to pulmonary atelectasis, as proved by autopsy findings This may have been caused by the precarious position in which the fetus remained for such a long period of time, as demonstrated by repeated x-ray examinations taken five weeks before delivery and, again, one day before delivery

Early interference by cesarean section may be indicated in such cases

642 Eastern Parkway

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chiefly because of serious physical impairments Heart trouble and high blood pressure constituted the chief causes of uninsurability, together account-ing for one half of all the cases Overweight was another important cause

Fewer than one half of 1 per cent of all persons applying for insurance failed to obtain it because of underwriting qualifications other than physical, including occupation, location of residence, applica-tion for too much life insurance relative to income, habits, or excessive drinking

A PSEUDOMUCINOUS CYST OF THE OVARY WITH ASCITES AND HYDROTHORAX

SAMUEL S ROSENFELD, M.D., F.A.C.S., New York City

(From the Department of Obstetrics and Gynecology Lebanon Hospital)

THE triad of ovarian fibroma, ascites and hydrothorax, described by Meigs and bearing his name has now been observed and reported upon many times Lest practitioners, and especially medical students come to believe that only oversan fibromata are capable of producing ascites and hydrothorax, I believe it of value to report cases in which neoplasms other than ovarian fibromata were the causative tumors

Calmenson, Dockerty and Bianco report 9 cases of polvic tumor in association with ascites and hydrothorax treated at the Mayo Clinic from 1910 to 1045 of these, 5 were ovarian fibromatas 1 a degen erating uterine fibromyoma 1 a fibromyoma of the uterus with pelvic inflammatory disease of the ad nexae, 1 a granulosa cell tumor of the ovary and 1 a complete teratoma of the ovary 1

Frankenthal reported a case where a theca cell tumor of the ovary produced ascites and hydrothorax.

This report is made for the purpose of adding to the literature another case in which ascites and hydrothorax were present not in conjunction with a fibroma of the ovary but with a massive pseudomucinous cyst

Case Report

Mrs. A. U aged 34 was admitted to the hospital because of swelling of the abdomen which she had noted about five months previously and which gradually increased in a uniform manner. There has been no pain or tenderness associated with the

swelling.

Lately, she has noted shortness of breath, especially on climbing stars and coughing when she shifts her position in bed. There has been no hemoptysis nor pain in the chest. She is occa sionally dyspnele Her appetite is poor and she be-lieves she lost weight Bowel movements are regu She has never noted swelling of the ankles nor

any enlarged veins in the lower extremities

The menses began at twolve and until five years ago the flow was moderate lasting five days and occurring at 28-day intervals. In the last five years occurring at 28-day intervals. In the last five years bleeding occurs every 28 days lasts nine days is very profuse and accompanied by sovere pain on the third day of the period. For the last two months also has been bleeding every fourteen days for seven days. She has one living child, three years of age delivered in the eighth month of gestation. There is no frequency of the period of the contract of the

is no frequency difficulty or pain on micturition.

Examination revealed a thin woman who evidently had lost weight and who had a distonded abdomonabdomen Numerous moles are scattered over the akm, especially large ones at the lateral ends of the clavicles The thyroid is not palpable. The heart is normal. There is absence of breath sounds and vocal fremitus extending from the right base to the seventh rib posteriorly. This area is flat on percussion. In the axillary line these signs extend to the apex of the axilla

The swell The abdomen is distended markedly ing is large uniform and corresponds in size to a twenty-eight weeks pregnant uterus No fetal heart sounds are heard. Small lymph nodes are palpable in both groins. There is no swelling of the ankles and no varicose veins are visible

The blood count on admission showed hemoglobin, 110 Gm. red blood count, 4 330,000 and white

blood count, 6,650

Differential count was polymorphonuclears, 68 per cent, lymphocytes, 26 per cent band forms 5 per cent, and mononuclears, 1 per cent. Sodimentation rate was 55 mm. after one hour (Westergreen). Blood Wassermann was negative

Blood chemistry preoperative showed sugar 68

Blood chemistry postoperative showed total pro-class, 6.2 Gm. per cent albumin 3 7 Gm. per cent and globulin 2 5 Gm per cent.

The urine on admission had a specific gravity of 1 032 and showed an occasional red blood cell and white blood call.

Radiographic examination of the chest and fluor oscopy disclosed pleural effusion on the right side extending to the level of the fourth rib in the axillary line No gross changes were visible in the left lung. There was no displacement of the cardiac shadow

Thoracentesis was performed and about 1 200 cc. of clear yellow fluid obtained. Culture proved the fluid to be sterile. Microscopic examination failed to reveal any tumor cells

The presumptive diagnosis was multiple uterine fibroids associated with either a papillary cystad enoma of the ovary or a fibroma of the ovary operation a massive pseudomucinous cyst of the right overy and a moderately enlarged uterus con taining several intramural fibroids, was found.

The ovarian tumor occupied the greater part of the abdominal cavity About two liters of free fluid, the abdominal cavity About two increases ince have, similar to that seen in the cyst cavity was free in the abdominal cavity. The left ovary appeared normal. There were no peritoneal implants. The liver and There were no peritoneal implants. gallbladder were normal.

The cyst was removed in toto except that a small daughter cyst apparently ruptured on the poeterior surface while the mass was being removed. The

abdomen was closed without drainage.

Dr Joseph C Ehrlich, the pathologist reported as llows Ovarian cyst, measuring 25 by 27 by 11 follows cm was completely encapsulated except at one end where there was a partial rupture about 3 inches Mucinous fluid appeared to be leaking this rupture The capsule of the cyst had across. through this rupture a very smooth deeply congested appearance with a few fibran deposits but no evidence of papillary implants. There was no necrosis nor hemorrhage visible from the surface. The cyst contained inplants. numerable daughter cysts of various sizes ggregate cyst content was calculated at about 14 000 cc and consisted of thick albuminoid yellow ish material. All of the cysts examined had a smooth lining There were no areas of solid tumor

Section revealed various evats lined by a single

layer of columnar cells of the mucinous or goblet type The stroma of the cyst wall was composed of rather cellular fibrous tissue which was quite vascular There was no histologic evidence of malignant character or invasive tendencies

Diagnosis —Pseudomucinous cystadenoma of the ovary

Summary and Conclusion

A case is reported in which ascites and hydrothorax were associated with a pseudomucinous cyst of the ovary and not a fibroma. Cases exhibiting the triad of ovarian tumor, ascites, and hydrothorax can easily be confused with ovarian malignancy and metastasis It is essential, therefore, that a thorough study and evaluation of the case history, physical, and laboratory findings be made before a patient exhibiting the triad is refused, or advised against, operation

The convalescence was uneventful and at this writing the patient is about ten weeks' pregnant

1882 Grand Concourse

References

1 Calmenson M, Dockerty M B, and Bianco J J Surg, Gynec & Obst. 84 181 (1947) 2 Frankenthal L E Jr Am J Obst & Gynec. 53 331 (1947)

MISSISSIPPI VALLEY MEDICAL SOCIETY ESSAY CONTEST

The eighth annual essay contest of the Mississippi Valley Medical Society will be held in 1948, and is open to any member of the American Medical Association who is a resident of the United States

A cash prize of \$100, a gold medal, and a certificate of award are being offered by the Society for the best unpublished essay on any subject of general interest (including medical economics and education) and practical value to the general practitioner of medicine Certificates of merit may also be granted to the physicians whose essays are rated second and third best

The winner will be invited to present his contribu-

tion before the thirteenth annual meeting of the Society, to be held in Springfield, Illinois, from September 29 to October 1, 1948, the Society reserving the exclusive right to publish the essay in its official publication, the Mississippi Valley Medical Journal

publication, the Mississippi Valley Medical Journal All contributions must be typewritten in English in manuscript form, submitted in five copies, not to exceed 5,000 words, and must be received not later than May 1, 1948

Further details concerning the essay contest may be secured from Dr Harold Swanberg, secretary, Mississippi Valley Medical Society, 209-224 W C U Building, Quincy, Illinois

ARMY MEDICAL CORPS HAS OPENINGS OVERSEAS IN SPECIAL FIELDS

The US Army Medical Department announces the availability of opportunities for advanced training and experience in the various special fields of medicine and surgery in overseas Army hospitals. These hospitals are registered with the American Medical Association, and this training may be acceptable by the specialty board as part of the period usually required to be spent in limited practice and experience prior to admission for examination.

Interested members of the medical profession who have completed the formal training requirements for certification in one of the special fields are eligible to apply for these positions. Openings available, as of January 1, 1948, which will be kept open until filled, include—eye, ear, nose, and throat, 7, ob-

stetrics and gynecology, 14, anesthesia, 7, ophthalmology, 3, otorhinolaryngology, 3, neurosurgery, 1, orthopedic surgery, 5, thoracic surgery, 1, plastic surgery, 1, radiology, 11, internal medicine, 24, dermatology, 3, neuropsychiatry, 15, pediatrics, 10, cardiology, 2, and pathology, 1

Eligible physicians are invited to communicate with the Surgeon General, US Army, Washington 24, DC, for further information Inquiries should include name, address, age, nationality, mantal status, dependents with age of each, medical school and graduation date, internship and date, details of graduate training, specialty and geographic location desired, contemplated length of service, and details of prior military service

Special Article

SOME ASPECTS OF THE PROBLEM OF THE NEW YORK STATE MENTAL HOSPITALS SYSTEM

Report by the Committee on Public Health Relations of the New York Academy of Medicine Prepared by E H L Corwin, Ph D and THELMA PIERCE, New York City*

THE care of the mentally ill is the outstanding medico-social problem of New York State An indication of its magnitude is the fact that 25 per cent of the annual operating budget of the state is expended for this service, and even this sum is numificient to meet adequately the needs of the state mental institutions. Whether there has been an actual increase in the incidence of mental disease or whether the increased admissions to mental hospitals indicate only an increased tendency toward hospitalization cannot be stated with accuracy The fact remains that the state hospitals are caring for patients in excess of their rated capacity, in some instances by more than 30 per cent.

That something must be done to relieve if not to remedy the situation is apparent. Competent bodies such as the American Psychiatric Associa tion have prepared thoughtful long range plans for the improvement of the state mental hospitals, The soundness of these plans is not to be questioned in point of the goals to be attained. Unfortunately, the implementation of the plans is not of immediate possibility partly because of the expenditures involved and also because of the lack of the necessary trained personnel. What is attempted in this report is not the delineation of an ideal but the formulation of practical suggestions for improvements which

The experience and observation of the members of the Committee have been complemented by information secured from the Commissioner of Mental Hygiene of the State of New York, from representative state hospital directors and from other sources. These data have been combined with those obtained from the comprehensive literature on the subject to form the basis for this report.

Principal Problems

Overcrowding of Institutions—Most of the problems of the state mental hospital administrators are aggravated by the fact that the majority of the institutions house more than their rated capacity The Annual Report of the Department of Mental Hygiene for the year ending March 31 1044, the last printed roport, stated that the number of patients in state mental hospitals was 14 6 per cent in excess of rated capacity. At the present time the overcrowding is from 25 to 35 per cent in the institutions that it was 14 for the present time the overcrowding is from 25 to 35 per cent in the institutions that it was 14 for the state of the present time the stitutions close to New York City

Many factors have contributed to the over crowding of the hospitals. Not the least important of these is the aging of the population which has increased the number of potential senile and artero-selerotic patients. The longthening lifespan will continue to contribute to this potential group. But perhaps the most important reason for the

Onder the guidance of a subcommittee composed of Charles Gordon Hayd, M.D., chairman Fraderick R. Balley M.D., Carl Bisger M.D. Hubert S. Howe M.D. and S. Bernard Wortis, M.D.

increase in the actual number of admissions of senile and arteriosclerotic patients is fundamentally sociologic. With the exodus of women into business and with the trend toward smaller living quarters the care of the aged in the homes of relatives has become well-nigh impossible. The aged are being placed in state hospitals if they exhibit even minor mental symptoms. This has resulted in crowding the wards of the state hospitals with patients who primarily require supervision.

It has been suggested that separate units for the care of scnile and arteriosclerotic patients be established in connection with either state mental hospitals or general hospitals, county or voluntary These patients need a type of care which differs from that required by other mental patients Their mental derangement however does necessitate the employment of personnel experienced in the care of mental illness For this reason homes for the aged would be unsuitable in that they would not provide sufficient protection for such patients.

Dementia praceox patients, who make up the largest percentage of the mental bospitals popula

largest percentage of the mental nospitals popula-tion 56 per cent will probably continue to require about the same proportion of hospital care in the future as they have in the past since the number of such patients on the hospital's books has varied little in recent years. The use of shock therapy and preventive measures may reduce the size of this group but the gain so obtained will not be appreciable until more effective preventive and therapeutic technics are devised and utilized. These require specially trained personnel in every state mental hospital.

It is regretiable that the experience with shock therapies is not being systematically and completely reported In addition, research in the blopletely reported In addition, research in the blo-logic physiologic endocrinologic and psychologic phases of domentia praecox is urgently needed Adequate programs for the study of this problem should be undertaken in the mental hospitals and provision should be made for stimulating contact with other research workers in this and allied fields.

Manic-depressive patients made up about 6 per cent of the first admissions to New York State large numbers of these patients were discharged either as recovered or improved it is well known that they form a high percentage of readmissions to the institutions. Present-day knowledge of this disease does not indicate great hope that the size of this group will be reduced greatly in the near future.

There are however, two groups of patients who to a large extent can be expected to disappear from the rolls of the state mental hospitals. The first the rolls of the state mental hospitals. The first of these groups is that of the general parctic pattents. New methods of treating syphilis and the program of public education with regard to early treatment of this disease should make possible an almost complete elimination of general parens in

the not-too-distant future Should this be consummated, there will be a release of 5 per cent of

the existing bed capacity for other types of patients

The second group of patients who can be
climinated to a large extent from the mental hospitals are alcoholics Few of this group require For the most part, alcoholic long-term care patients admitted to mental hospitals are suffering from acute episodes and do not need the type of care which the state mental institution is planned and equipped to render. With few exceptions, alcoholic patients can better be cared for in special divisions of general hospitals. A period of observation in the general hospital, of sufficient length to determine the probable duration of the aberration, would make it possible to eliminate from the state hospital rolls all but those few alcoholic patients whose mental illness is of a per-Proper methods of treatment manent character designed to reach the root of the difficulty and carried out in a special unit of the general hospital. should make it possible for many alcoholics to return to society, those who are irredeemable should

be placed in appropriate farm colonies

A procedure which could be expected to result
in the reduction of the number of patients in the
state mental institutions is that of the re-examination and possible rediagnosis of all patients often patients who apparently require only custodial care are relegated to the "back wards" of the institutions where they may not be seen by a com-petent psychiatrist for months and sometimes longer A certain percentage of these patients might, with proper reconsideration of their condition, be discharged, placed on "convalescent status," or sent to "family care," a form of foster home care Any one of these dispositions would relieve the pressure on overworked staffs

It is recognized that the reclassification of all state mental hospital patients is a gargantuan task and one which may well be beyond the physical capacity of the psychiatric staffs of the institutions It might be possible, however, to obtain the services of teams of outside psychiatrists to assist in this work of reclassification. The over-all benefits of such a task might well justify the expense for such Staffs should be adequate to make a service periodic examinations of all patients and thus obviate the necessity of undertaking such a task at a particular time

The "family care" program of the state mental hospitals should be re-evaluated The remuneration of persons undertaking this type of responsibuilty should be brought to a level which would make it possible to obtain suitable homes for the patients and which would induce more families to accept patients Many patients might be of service to farmers, for example, and the shortage of man-power in the agricultural field should interest farmers in taking on such helpers if the allowances were consistent with the present cost of hving

The establishment of adequate clinics for outpatient care throughout the State would prevent the commitment of some patients by providing ambulatory psychiatric service for them, it would make possible the release of patients who are now in institutions only because they need supportive therapy which at present they otherwise cannot obtain. The sooner a mental patient can be returned safely to his community, the less is the danger of his becoming "institutionalized" and requiring a prolonged or permanent stay in the hospital

At no time should a patient remain in a mental

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hospital because of the contribution he may make

to any service of the institution

Understaffing—Whenever it becomes necessary to crowd patients in an institution the task of caring for them mounts in a geometric ratio sufficient space necessitates the use of recreation rooms as dormitories and thus makes more difficult the provision of proper exercise and relaxation for The crowding of wards makes thorthe patients ough cleaning a problem and adds to the likelihood, of friction and irritation among the patients. These and other factors call for the employment of additional personnel Unfortunately, most state mental hospitals have available less than their approved quotas of all types of personnel

The low salaries paid by the state hospitals make impossible the attraction of attendants of a caliber able to contribute to a constructive recovery Inadequate examinations and the necessity of hiring such personnel from Civil Service lists aggravate the problem And inept handling by an attendant can retard the progress of a patient

for months, or even permanently If the psychiatrists provided for in the New York State budget were in service, the ratio of patients to psychiatrists would be 161 to 1, actually it is 187 to 1. The lack of sufficient psychiatric staff precludes proper psychotherapy for many patients Patients who receive shock therapy require, for best results, complementary psychotherapeutic interviews. These interviews need not be lengthy but should be held daily to make certain that the patient obtains proper insight into his condition and is thus in less danger of a relapse

Low salaries, unsuitable housing, and the poor quality of the food make state mental hospital work unattractive to ambitious and alert psychia-When to these factors are added a lack of contact with other medical disciplines and a lack of a stimulating program of treatment and research, the difficulties in obtaining trained psychiatrists for the state institutions are increased

Those responsible for the administration of New York's mental hospitals constantly appeal to the Legislature for additional funds with which to do a proper job, often without avail Even in the face of this handicap, it might be possible to attract young men and women if sufficient intellectual stimulation and a good work environment were offered

A program which would provide additional hospital personnel and which would be of benefit to all future physicians would be the inclusion of a three-month residence in a mental institution as a part of the regular rotating internship plan presupposes a regular hospital staff competent to train young men, an active program of treatment, and, wherever possible, research

Those mental hospitals which aspire to train psychiatrists must of necessity have adequate staffs and proper facilities for training number of psychiatrists needed in the United States is estimated at 10,000 at the present time. We have but 3,500. Only an active, forward-looking mental hospital program can meet the need

The housing and maintenance of state hospital personnel should be improved wherever it is below In those institutions in which there is a standard shortage of space, the possibilities of temporary or permanent outside housing for employees should be Attractive housing of employees is an considered important factor, since maintenance constitutes a large portion of their remuneration Apparently, it is difficult or impossible to obtain additional money

When most of the mental hospitals were built, the prevailing opinion was that psychotic patients should be seen as little as possible, the basic reason for placing such matitutions in rural locations. A little of the superstition of "possession" still clings to

mental disease
A step toward the cradication of this medieval
attitude would be to place mental hospitals in
urban locations where they would stand in the
current of general medical activity. This change
upon a period of training in the care of the
mentally ill It would make possible the patients'
the visits of relatives and friends, and it would keep
the visits of relatives and friends, and it would keep
the visits of relatives and itsenting a forward
approach similar to that of other types of institutions for the care of the sick

In view of the reports that mental illness occurs in about one out of every five families in the United States, that much of such illness can be prevented or allevisted by proper treatment, that mental better and more training should be provided for those interested in working with mental patients, it is imperative that the facts of the present situation be brought to the attention of the proper authorities, and particularly of the legislators, in order that adequate preventive and curative measures may be provided.

Summary and Recommendations

In approaching the whole problem of the care of the mentally ill, it was realized that there might be no finality to the conclusions reached, that the problems and their solutions might change with problems and their solutions might change with changing conditions. At present, however, the mental hospital administrators of the State of the Mw York face difficult and numerous problems, not patients than the rated capacity of their institutions. Lack of adequate funds makes impossible the procurement of sufficient and competent personnel. Obsolete buildings in had competent personnel. Obsolete buildings in had competent procurement of sufficient and of them located in remote sonnel. Obsolete buildings in had repair and of medicient design, many of them located in remote places and away from contact with progressive medical procedures, and to the complexity of the sutuation

Public indifference to the fate of mental patients reflected in the depersonalization of the care rendered to state hospital patients. Research is needed in the hospitals, not only to determine some of the possible physiologic causes of mental disease but also to act as a stimulus to attract alert and program presupposes competent personnel and program presupposes competent personnel and program presupposes competent personnel and mould make possible the establishment of urgently meeded training centers for interns and medical students

Because it is apparent that immediate measures must be taken to alleviate certain manifest deficiences and that plans must be laid for the future, recommendations should be based on three proximate measures of time

I Immediate—to correct existing deficiencies in the shortest possible space of time and with the least possible expenditure of funds

2. Interntediate—to project short-range pro-

The microscape expendence of the property of the state of

and would preclude the commitment of many patients. The Plan estimates that 8 beds per 1,000 population are needed for mental patients, of these, 0 3 bed per 1,000 population should be provided in general hospitals.

It has been recognized only recently that much of mental illness has its origin in the maladyistments which arise from life in an increasingly complex society. Psychiatric clinics are needed for those who find themselves faced with problems beyond who find themselves faced with problems beyond which another competent payentairs guidance might be obtained at low cost. Because of the lack of such facilities many persons with early symptoms of mental illness grow promitted eating worse until commitment to a state mental pospital becomes the only solution Accurate estimates of the number of persons who could have estimates of the number of persons who could have madications are that the number of persons but all indications are that the number of persons undications are that the number would be large to estimate the contractions are that the number would be large orders on the properties of the average citizen too expensive for the average citizen

Psychiatric clinics would serve still another purpose They would make possible the discharge from mental hospitals of many of those patients who remain in the institution solely for supportive treatment. With the establishment of proper clinics these persons could live in the community and, in some cases, might be able to work and to earn at least a portion of their own expenses.

The value of adequate psychiatric facilities for young persons cannot be overestimated The value of schools of

bered that schizophrenic patients constitute the bulk of the state hospital population. The variety of groups which could be served by

The variety of groups which could be served by well-run psychiatric chinics is too great to enumerate To mention only a few the courts of domestic quency, boards of education and health, visiting nurse or faminate in wellare agencies. Funds for the maintenance of these chinics should be provided by the state. To accomplish this, it may be necessary to amend the eliating state law.

Dr George S Stevenson, medical director of the National Committee for Mental Hygiene, has stated that, "What we need today is an entirely new concept of public psychiatry". At present, "Public psychiatry is not focused on the community where the mental problems originate and to which where the mental problems originate and to which

Public psychiatry is not focused on the community where the mental problems originate and to which the patient must return if treatment is successful What we need is to realize that the mental hospital constitutes only one aspect of the whole field of public psychiatry."*

The psychiatry was a specific to the whole successful to the second of the whole second or t

The rapid growth of the American hospital system has resulted in an emphasis on the hospital rather than on the patient. A hospital-focus rather than a patient-focus is noted in the state mental hospitals. The individual is lost in the mass. He becomes but the bearer of a diagnostic label, his name is frequently unknown even to the nurse on harmy ward

This depersonalized attitude is due in greater part to the enormous size of most of the New York State mental institutions. In smaller part it is due to a merry-over of public indifference to the fate of the wantedly ill Public thinking has not yet advanced to the stage where it can recognize that ill-past of mental character is no less an illness that is that of physical character.

* Stevenson George S. Needed A Plan for the Mentally Ill New York Times Magazine, July 27 1947 p Ill

nse them etate mental bospitals, and the staffs trained to

More latitude than new exists should be given to the molecular in statical postilities in the molecular to the molecular in the solution of the molecular in th dotermine the qualifications of those persons. 11 For attendants, a period of training should be followed by a Cavil Service examination to

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provided.

Future-to outline plans which are basic

apple considering immediate and interim measures. There is an intentional overlapping of the three

neen made to keep in mind the future ideal even types of recommendations because an attempt has rather than merely remedial

The Committee recommends that the following

immediate steps be taken to improve existing de-

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hypertenavo and arientedeptiele. Although many of these patients require active psychiatric care attantion is the lengthening lifespan. Because of economic and social conditions, as well as the lack of other facilities, large numbers of senile The existing overcronding should be lod. An unportant causative factor in this remediod

provent the present neglect of these large groups poshiral, separate units for the proper care and entrinons or the county and voluntary general catablish, in connection either with mental inwould seem advisable therefore for the State to and trained supervision their physical degenera-tion calls for appropriate medical attention it

Most alcoholic patients, likewase, do not require or the aged.

duceted to state mental hespitals. Tuberculosis care for alcoholic patients and unless there is evidence of psychosis these persons should not be opecial unite in general hospitals are more suited to can give, Savo for alcoholic psychocas theur

nothed to werver olboring a patients. A systematic policid of third both build be believed with the both of the both of the best of the patients of the patien the purpose.

separate units equipped and staffed specifically for

of big ameliacy learness to earn out to somed restents and to or in 'family care,' program should be ox 2 The 'family care,' program should be made to seeme more

bring the rates of payment for such care to lovels

in leoping with the present costs of living.

4. Stimulating to roughout a cost of crostmont, in which each staff member would particlemont, in which each staff member would particlemont, in which each staff member would particlemont, in which the present of the particle of the

b Every effort abound be made to attract acompletest personnel through adequate scalaring and good furthing conditions, food, housing, provides of stimulating work opportunities.

B. Efforts should be made to obtain larger and better the conditions to the conditions to the conditions of the conditions are set of the conditions of the conditions are conditions.

of revenue for needed improvements. lo use ofly to strain and collection methods. Support investigation and collection methods. Such procedures might constitute an extra source of experimental for such procedures and support of the collection for such procedures and support of the collection of the

doternino whether minor alterations in present be spared to maine proper sanitation and ado-duato folds and bathing lacilities.

S Expert architects should be consulted to T Executed repears to existing buildings should be made without delay No effort should

lle ni batutiteni od bluoda ebodiom insmitani the fullest possible extent modern execute games of the buildings might result in a more efficient use of the

as well as the psychologic lactors of mental dusaces. Adequate and prepare facilities, equipment amount in the payer and research ment, and research for therapy and research work abouid be provided. The hospitals abouid to conduct sound researches in the physicologic

to those of administrative work, not be dependent upon transfer to administrative duties. Clinical work should carry rewards equal State hospital service and advancement should

the case of the physicians, the remuneration should be sufficient to attract competent men to with their professional training thour period of

The remuneration of physicians, nurses and in keeping,

mante proper preventive outpatient care and sufficient and adequate paychatric cluucs to gacta equit spong pe made to estupitaly

tor the care of the mentally ill. Paychlatric units in general hospitals should be mainteined by State of federal aid. Existing laws should be

City should be incorporated in the evolving plans

tions of the Inscident Psychiatric Association and the Mow York As many as feasible of the recommendaview to their use in the other diate institutions. zation, and construction could be tried out with a as an experimental unit, In such a unit now as a proposed a treatment, administration, organization and the such a treatment of the treatment

future, it might be advisable to designate enther a new hospital or one of those now in existence

the State mental institutions in the immediate

operate efficiently no hospital should have more consenue of competent expert opinion is that to

upon the size of the metitutional units.

conditions as well as to paye the may for future

interimediate stops be taken to improve existing The Committee recommends that the following

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bodies. The tales economy of short-sighted bodies and equipment policies and antiquated methods and equipment

evitalials of the bublic and to the legislative

of public per chiatric care should be brought to the The inadequactor in the present system

In bluder of oldbeequu if it in doumann! may become affiliated with teaching institutions

New mental hospitals should be located in

A definite innutation should be imposed ning board to formulate a definite, concards, integrated policy or program for the future care of the monthly ill.

Tuote enoute be set up a long term plan

treatment, as well as posthospital attention

amended to make this possible.

siderably smaller units.

should be emphasized.

Every state payohiatrio service should be well-stalled and should be setlicated by a spirit of secontific endeavor. The stall should be qualified The following points should be borred in mind far following for the future

663

4 Efforts should be made to obtain trained chaplains for mental hospitals All hospitals having trained chaplains should provide opportunities for the clinical training of theological students

5 Psychiatric clinics for the prevention, diagnosis, and treatment of mental illness should be established in suitable localities and in such number as to provide adequate psychiatric care for the entire population Proper facilities for the diagnosis, treatment, and care of the young psychotic, particularly, are needed

6 The public should be enlightened concerning mental illness, its prevention, and facilities for treatment. This wast undertabling should be directed by highly qualified persons with the Mental Hygiene Committee of the New York State Charities Aid Association

be of moderate size and should be located in urban centers. It should be emphasized that urban centers it should be emphasized to the community in which they are located, the procommunity in which they are located, the procommunity in which they are located, the procommunity is sometimed and all the process of some should be should be supported in the state of some 2 Every state psychiatric service should provide comprehensive training programs for both young psychiatrists and general interns. Affiliation should be arranged with general hospitals to provide psychiatric training for all student nurses, special provisions should be made for the graduate

training of psychiatric nurses

3 Every state psychiatric service should
afford opportunities for the clinical evperience of
such auxiliary workers as social workers, clinical
psychologists, recreational therapists, physiotherapists, recreational therapists, and hydrotherapists

PROS AND COMS OF AIR SANITATION

The potentialities of an sanitation in the control of a wide variety of respiratory and infectious diseases appear to be great, but concrete results have not yet maternalized, according to Dr Alexander Langmunt, associate professor of epidemiology, Johns Hopkins University This situation he attributes to epidemiologic limitations rather than to engineering technics

As commonly used, the term "surborne infection" applies to a large group of respiratory and contagious diseases and also to skin and wound infections Yet, for many years these same diseases have been considered almost universally to be contact infections if there are four routes by which they travel from one individual to another contact, droplet, droplet, and dust

droplet nuclet, and dust

The term "surborne infection" should be restricted, Doctor Langmur explained, to the transmission of disease through the air vith distances of more than three feet between the infective source and three feet between the infections are incore than three feet between the infections are dusting a regiment in such infection—droplet nuclei and dusting against n high four types of technics are considered assumet n high four types of technics are considered most useful

Alcohanteal ventilation by the introduction of clean filtered arr in controlled currents achieves a limited removal of droplet nuclei and dust. This method is uneconomical and inefficient in most occupied appaces as a means of dismicecting arr but has wide application in the general field of air conditioning and particularly in specialized fields such as surgical and particularly in specialized fields such as surgical operating rooms

In aummary, Doctor Langmaur said that effective engineering technics for the disinfection of air are available. These are useful in preventing the spread of disease in a few limited environments where air is, surgical operating rooms, pediatric and contagone infection is an important mode of transmission, i.e., surgical operating rooms, pediatric and contagons userial, and research laboratories where agents of human disease are under investigation. Controlled studies in other environments such as schools and institutions, military and naval barracks, and sanatoria and mental hospitals, offer best prospects for extensing mental hospitals, offer best prospects for extension of air sanitation—Health Neus, October 20, 1947 sing of air sanitation—Health Neus, October 20, 1947

highly efficient method of dust suppression in hospital wards, dormitories, and military barracks. It effects markedly visible reduction of dust in the air and a striking quantitative reduction in the number of bacteria recoverable from the air during periods of

Oiling of floors, and bedding and other fabrics is a

one distinct advantage over ultraviolet light in that they may permeate all parts of the room. They have

Desired person are supported by the recipient Disnifectant unports, of which triethylene glycol appears to be the most potent, also are limited in appears to be the most potent, also are limited in their action to the small droplet nuclei. They have

prevent only those infections acquired by droplet nuclei which travel the circuitous route from the infected person into the upper air and then down again

droplet nuclei. The maximum that can be expected from ultraviolet lights is that they will reduce or

Ultraviolet irradiation is effective primarily against

ittle or no effect on dustborne infections

not include any other part of the human body treatment of fractures shall be limited to simple, un complicated fractures of the phalanges The use of anesthesia shall be limited to local anesthetics for therapeutic purposes as well as for anostheria, and the right to use non-narcotic postoperative sedatives

After discussion, it icas roled that the Council send word to the podiatrists through Dr. Dattelbaum s committee that if they introduce legislation within the framework of this and not exceeding it the

Medical Society will not oppose it

Constitution and Bylaws.-Dr Rouling chairman reported he had received a letter from the Secretary Dr Anderton, suggesting that the following changes be made in the State Society Bylaws in regard to election of delegates to the American Medical Association in order to conform to A M.A proposed changes add the following clause to the first son tence in Chapter III Section 7 "to commence the first day of the January pext succeeding each dele-gate s election. The Section would then read "The delegates to the American Medical Association shall be elected in the calendar year preceding the meeting of the House of Dulcgates of the American Medical Association to which they are elected and in accordance with the Constitution and Bylaws of that body for a term of two years, to commence the first day of the January next succeeding each delegate's election. Delegates may be elected to other medical societies or similar bodies as the interests of the Society may roquire, and credentials shall be issued to all delegates, signed by the President and Secretary

It was roted that this be introduced at the next session of the House of Delegates from the

Dr Andresen stated a similar change should be made as applying to County Medical Societies

After discussion it was roted to refer this proposal to the Committee on Constitution and Bylaws for

study and report at the next meeting Report of Delegates to the American Medical Association House of Delegates.—Dr Winslow chairman of the Delegates made the following

Our Society was represented at the 1948 interim meeting of the House of Delegates of the American Medical Association in Cleveland Ohio on January

5 and 6 by

Walter P Anderton Herbert H Bauckus, Albert F. R. Andrewn Thomas M. Brennan James R. Reuling Floyd S Winslow, Ralph T B. Todd, O W. H. Mitchell Edward P Flood Albort A. Gartner Thomas A. McGoldrick, John J. Masterson, Stephen B. Mostelik J. Strate, Konvey Cooper, W. Kon. R. Monteith J Stanley Kenney George W Kosmak Thomas M D'Angelo Harry Aranow John T Donovan Scott Lord Smith, Walter W Mott

Dr Mitchell was appointed Chairman of the Reference Committee on Reports of Board of Trus-

tees and Secretary

Dr Andresen was appointed Chairman of the Reference Committee on Executive Session

"Dr Aranow was a member of the Reference Committee on Rules and Order of Business

'Dr Anderton was on the Reference Committee

on Hygiene and Public Health. "Dr Masterson was a member of the Reference

Committee on Medical Education 'Dr Winslow was a member of the Reference Committee on Miscellaneous Business

'Dr Todd was a member of the Reference Com mittee on Medical Service

'Dr Kenney was Chief Sergeant at Arms.

In addition to the regularly elected delegates from our society, Dr Roy B Henline was delegate from the Section of Urology and Dr Arthur J Bedell represented the Section of Ophthalmology Also present were Dr Louis H Bauer, a trustee of the American Medical Association Dr Edward R. Cunniffe, chairman of the Judicial Council of the American Medical Association Dr Laurance D Redway, literary editor of the New York STATE JOURNAL OF MEDICINE, Mr Dwight Anderson, carcutive secretary, Mr Thomas E. Walsh, public relations representative and Mr Gordon Marshall, advartising representative Our delegation ably represented our Society and took an active part in the proceedings Minutes of the meetings will appear in the Journal of the American Medical Asso-

It was voted that the term of office of delegates is to commence the January first following their

Economics.-Dr Wertz chairman referred to the following report of the Director of the Bureau of Medical Care Insurance

"The Subcommittee on Medical Expense Insur ance held two seemons one in New York at the Society offices, and one in Buffalo Docember 8 and Mr Farrell attended both sessions proposed program of Committee activities for 1948 was adopted as outlined in the Bureau report to the Council at the November meeting

December θ, 1947 Mr Farrell spoke before the Woman's Auxiliary to the Medical Society of the County of Orange at Middletown on the general principles of prepaid voluntary nonprofit medical

care insurance.

"January 5, 1948 As directed by the Subcommittee Mr Farrell visited the executive director of the Genesee Valley Medical Care Plan Rechester to discuss the Committee's recommendations on correspondence referred to it

"January 8 1948 On invitation of Dr O W H Mitchell, Mr Farrell spoke before the senior medical students of Syracuse University College of Medicine on 'The Economic Aspects of Medical Care Insur-

January 7 1948 The Director visited the Medi cal and Surgical Caro Plan Utica, to discuss that part of the Committee s program for 1948 in which

the plans are to participate.

Report accepted

Ethics.-Dr James R. Reuling, chairman made

the following report

There was referred to the Committee on Ethics the new insertion Section 31 (b) that was adopted by the House of Delegates It was headed Publica tions for the Laity I will read it to you as it was adopted by the House

Publications for the Laity Members of this Society who have prepared and written a book, article or any writing pertaining to medicine for the lasty and intended for publication shall submit the same to the Council Committee on Public Relations and the Public Relations Bureau of the Medical Society of the State of New York for approval prior to any publication thereof In the event the book article or writing shall be so approved for publication then and in that event any proposed advertisement for or announcement of publication thereof shall be likewise submitted to the said Council Committee and Bureau for approval prior to any appearance thereof The reviewing committee shall render its in print opinion without unnecessary delay This committee shall be in the main guided by Section 31 of the Principles of Professional Conduct, but shall be empowered to make such concessions as may be practiced and necessary in considering the title of publication, the description of the content, the responsibility, standing, and reputation of the writer, and such other material through which the publisher wishes to arouse reader interest'

"That was referred back, and the Secretary now proposes that instead of 'Publication for the Laity,' this be headed 'Advertisements and Announcements of Publications for the Laity,' and that it read

"In the event that there is proposed any public announcement of or advertising in relation to any book or article or writing for the laity, such proposed announcement or advertising matter shall be submitted to the Council Committee on Public Relations prior to any public appearance of such an-nouncement or advertising matter This reviewing committee shall render its opinion without unnecessary delay It shall be guided mainly by Section 31 of these Principles of Professional Conduct, but shall be empowered to make such concessions as may be practiced and necessary, in considering the description of the title and contents of the publication, the professional standing and reputation of the author, and such other material through n hich the publisher may wish to arouse interest

"I think that takes away everything that has been objectionable in what was adopted by the last

House, and it refers now only to advertising

"For the sake of getting it before the Council I am going to move that this be approved by the Council for submission to the House of Delegates"

After discussion, it was voted that this report be approved and take the place of the report that was accepted at the previous meeting of the Council

Malpractice Insurance and Defense Board.—Dr Thomas M D'Angelo, chairman of the board presented an informative report to be considered in connection with the report which was made at the last meeting

Office Administration and Policies —Dr Anderton reported for Dr Masterson, chairman, as follows "The committee met on Tuesday, January 13, and considered routine matters of management and office procedure, also a bill from the Century Moving & Storage Company, for moving goods and chattels from the twenty-first to the seventh floor of 292 Madison Avenue, was explained by Miss Dougherty to the satisfaction of the Committee and referred to the Board of Trustees Dr Masterson requested information regarding who was in charge of the office when both Dr Anderton and Mr Anderson are absent at meetings and in regard to the survey of work in the office He was informed that Miss Doris Dougherty, Administrative Assistant, is in charge of the office when Dr Anderton and Mr Anderson are both absent "

Public Health and Education —Dr Bauer stated that Dr Mitchell, chairman of the Committee, had to attend an important meeting of the Committee on Hospital Planning for New York State, in Albany, so could not be present His report as distributed

with the agenda is as follows

Activities of the Chairman—On December 30, 1947, in Syracuse, conferred with William E. Ayling, M.D., Health Director, School Health Service, Syracuse Department of Education

January 5 and 6, 1948 Attended the meeting of the House of Delegates of the American Medical

Association in Cleveland, Ohio

January 14, 1948 In New York City the Council

Committee on Public Health and Education held the following meetings With the Subcommittee on Hard of Hearing and the Deaf, officers of the Medical Society of the State of New York and representatives of the State Departments of Health, Education, and Welfare, with the Subcommittee on Mental Hygiene and officers of the Medical Society of the State of New York, with the Subcommittee on Child Welfare, the newly appointed Subcommittee on Rheumatic Fever, officers of the Medical Society of the State of New York, and representatives of the State Department of Health

Postgraduate Education —Postgraduate instruction has been completed in the following counties Chenango, Onondaga, Otsego, Ulster, and Wayne

Postgraduate instruction is being given in the following counties Clinton, Jefferson, Nassau, Ontario, Richmond, St. Lawrence, and Schenectady. Arrangements for postgraduate instruction are being completed for the Suffolk County Medical Society to be given in the near future

Dr Post, member of the Committee, was present

and made the following report

Subcommittee on Mental Hygiene—"The Subcommittee on Mental Hygiene held a meeting January 14, 1948, at the Society's office They are contemplating bringing out a severe criticism of the present conduct of the State in its care of the mentally disabled The New York Academy of Medicine has issued a report, which probably many of you have seen, and our subcommittee has approved it in principle The report from your subcommittee is being prepared"

Subcommittee on Hard of Hearing and the Deaf—
"The Subcommittee on Hard of Hearing and the Deaf held a meeting January 14, 1948, at the Hotel Roosevelt They are working in very close relationship with the State Department of Health in attempting to establish centers There are four, I believe, in New York City for assisting the deaf in the use of the proper appliances. It seems that the deaf do not know best how to secure a hearing device, and there is a lot of exploitation of them, which this committee is attempting to correct."

Subcommittee on Child Welfare—"The Subcommittee on Child Welfare held a meeting January 14, 1948, at the Hotel Roosevelt in conjunction with the State Department of Health The Baby Book' was discussed and endorsed by the subcommittee This has been prepared and will be distributed by the

State Department of Health"

Subcommittee on Rheumatic Fever—"The Subcommittee on Rheumatic Fever held a meeting January 14, 1948, at the Hotel Roosevelt We are very much interested in the Masonic Fund We are well represented on its advisory board. This money will be devoted largely to research in rheumatic fever and allied conditions"

Study Committee on Geriatrics—Dr Bauer stated that Dr Mitchell would be requested to distribute Dr Monteith's report on geriatrics to the Council before the next meeting because of its length. He urged the Council members to read it carefully before taking action on it

Public Relations —Dr Winslow, chairman, presented the following report

"Mr Anderson and Mr Walsh attended the meeting of the American Medical Association in Cleveland, January 5 to 9

"Copies of '20,000 Years of Service' are scheduled for delivery the week of January 19, and distribution will be made immediately

"An order for 1,000 copies of 'Check and Double

Check' came from the Medical Society of the State of Pennsylvania, and an order for 100 copies from the Association of American Physicians and Surgeons

Inc

In cooperation with Dr Bauer, a letter was prepared and sent to each county medical society president, on the need for county societies to appoint committees on public education with speakers selected to inform the public on social econome, and legislative matters Editorial comment on this letter will appear in the February 1 issue of the Journal.

"Editorial assistance was given the Woman's Auxiliary in connection with the Distaff The mid winter issue was distributed through the facilities of

the Public Relations Bureau

On December 9 Mr Walsh spoke before a joint meeting of the Herkimer County Medical Society and the Woman's Auxiliary on the subject of public

relations

"The following postgraduate sessions, held under suspices of the Committee on Public Health and Education, were covered by releases to the press Clinton, Jefferson Onondaga, Otsego, Richmond Schemetady, and St. Lawrence counties also the Geneva Academy of Medicine and an Industrial Health Teaching Day in Rensselaer County Publication.—Dr. Kosmak reported that the

Publication.—Dr Kosmak reported that the Publication Committee held its regular monthly meeting January 13 1948 Most of the business was of a routine character —A number of letters of criticism of editionals had been received which showed that our editorials are being read. The Committee has developed a now list of medical consultants for the State Journal. Note was taken of the increased costs of publication likewise the diminution in advertising revenue For January 1948, the estimated fall was \$3,000 Various directory matters were discussed pertaining to inclusion of certain institutions and organizations

It was voted to have the Convention issue of the

JOURNAL appear on April 1

Rural Medical Service.—Dr Mellen chairman stated there would be a meeting of the A M A. Committee in Chicago on February 6, 1948.

mittee in Chicago on February 6, 1948.

Liaison with Veterans Administration.—Dr
Anderton reported that the following letter had been

received from Dr Bauckus, the chairman

I have herewith certain information which I respectfully request you to submit to the Council at

its meeting on January 15 1948.

"Dr Ethan Flagg Buller Medical Branch Director of the Veterans Administration for New York State, has written to ask me to meet with him and Dr J C. Harding, Washington, D C of the Veter ans Administration, in New York on Thursday, January 22. The purpose of the meeting as stated by Dr Buller is to discuss fee scales and such other subjects as may be presented. I have accepted this invitation and therefore, feel I need not report per sonally to the Council until after this meeting Therefore, I ask to be excused from the meeting of January 15.

No announcement has been made of the appointment of a new Medical Director by the Veterans Ad-

ministration

As soon as thus is done we shall begin prepara with that official. The Special Veterans Committee of the A M.A. of which I am chair man, is planning also to meet with the new appointee

On December 13, 1947, I met with the presidents of the five metropolitan counties in New York City

These men all expressed dissatisfaction with the trend in the veterans medical care plans and we had considerable discussion as to ways and means of implementing their objections. I think further progress in this direction must also await the new VA Medical Director

'I was informed that as of January 1 1948, the proposed transfer of neuropsychiatry treatment to the Veterans Administration clinic actually took place. The reactions to this limitation remain to be

#00T

"Throughout the State there are still many authorizations allowed for medical care by the private physician chosen by the veteran. However unless the new director adopts a new policy which will also be followed in New York State I think the trend

away from private care will continue

"I should like also to report for the Veterans Liaison Committee that this committee mot on December 11 The findings of this committee very largely supported the present fee schedule We have not discussed this specifically with the Branch Director I shall ruport on this phase of the matter following the meeting with Drs. Butler and Harding on January 22

I shall be very glad to follow the wishes of the Council in furthering a practical program for vet

crans medical care.

Workmen's Compensation —Dr Kaliski director of the Workmen's Compensation Bureau procented the following report for Dr Kenney, chairman who was attending an important meeting in Albany

'On December 15, 1947, an open hearing was held on the minimum Medical Fee Schedule under the Workmen's Compensation Law at 30 Centre Street, New York, Miss Mary Donlon chairman of the Workmen's Compensation Board, presiding

The members of the Committee appointed by Miss Donlon to consider a royssion of the fee schedule consisted of Dr Nathan B Van Etten, Dr W P Anderton Mr Edward W Edwards Mr Martin

Hilfinger and Mr Henry D Sayer

The State Medical Society was represented by the chairman of the Workmens Compensation Committee, Dr. J. Stanley Kenney, and the director of the Workmen's Compensation Bureau, Dr. David J. Kalski. Thore was a fairly large representation

from various parts of the State

At the bearing the chairman announced that the committee had already accepted a number of the suggestions made by the Workman's Compensation Bureau of the Medical Society of the State of New York regarding changes and rovisions in the proposed schedule. Your director introduced a considerable number of additional changes. Representatives of the various county medical societies and special groups were given an opportunity to be heard. It became apparent at the hearing that sufficient time had not been given to the constituent county medical societies to enable them to give full consideration to the proposed fee schedule.

After conforming with the members of the comnittee Miss Donlon gracously extended the period of time to February 1 in which the State Society and the constituent county modical societies or other interested groups would be permitted to make sug

gestions to the Advisory Committee

Your chairman and director brought to the attion of Miss Donlon and her committee the fact that the Council of the Medical Society of the State of New York felt that physicians throughout the state should not be limited to the minimum charges in cases where executives of corporations were in sured under the provisions of Section 54, subdivision 6 A plea was made for a change in the rules or in the Law governing charges for services to executives of corporations

"The chairman of the Advisory Committee asked your director to confer with him on the proposed fee schedule and such conference was held on Monday,

January 12, 1948

"A notice was sent to all county medical societies on December 18, 1947, requesting them to bring the proposed fee schedule to the attention of interested physicians and specialty groups in their counties and to send their suggestions as to fees and other matters concerning medical care to the Bureau for submission to Dr Van Etten It is expected that the Advisory Committee to Miss Donlon will make its report in the near future

"Under date of December 15, 1947, the chairman of the Workmen's Compensation Board announced new rules with respect to ratings of medical examiners on the staff of the Workmen's Compensation Board Physicians employed as medical examiners on the staff of the Workmen's Compensation Board are not permitted to accept compensation cases or to render medical care under the Workmen's Compensation Law All workmen's compensation ratings of the Board's examining physicians stand suspended

and may not be used

"There is established for these physicians a special identifying designation of WCB, effective only during their term of service on the Board staff, which signifies that the physician is a member of the Board's staff of medical examiners and qualified, according to his education and experience in internal medicine, surgery, or other specialty. This designation does not authorize such physician to render medical care under the Workmen's Compensation Law. "An examination in roentgenology for eight can-

didates in diagnostic roentgenology and/or radiation therapy was held on Tuesday, January 13, at the New York University Medical College, First Avenue

and 28th Street, New York City, at 3 PM

"The following examiners participated in these examinations Dr Charles Wadsworth Schwartz, chairman, Dr E Forest Merrill, Dr Henry K Taylor, Dr Charles Gottlieb, Dr Ira Kaplan
"Your chairman in accordance with the action of

"Your charman in accordance with the action of the Council, has written to Dr Frederick MacCurdy, Commissioner of Mental Hygiene, concerning the certification of physicians employed in the State Mental Hospitals under the Workmen's Compensation Law, in accordance with the decision rendered by Attorney General Nathaniel L Goldstein, which was included in the minutes of the last Council meeting

"A meeting of the Joint Council of the Medical Society of the State of New York and the insurance carriers and self-insurers is scheduled for the near

future

"At the last meeting of the Council, it was voted that the State Society use its influence to see that the bill introduced last year by Mr Bewley, Senate Introductory 722,1947, "To amend the Workmen's Compensation Law in relation to the maintenance of medical bureaus by groups of employers, in counties of one hundred thousand population or less,' be opposed, if introduced again

"A communication was received from Dr Charles E Goodell of Jamestown, Chautauqua County, seeking the support of the State Medical Society for such a bill this year Dr Anderton has already notified Dr Goodell of the action taken by the Council dis-

approving this bill

"It has always been the policy of the Bureau and. I believe, of the County Medical Societies and the State Medical Society to act as a unit in workmen's compensation matters for the best interests of the public and of the largest number of physicians This has been our policy throughout the State since 1935, when we proposed a single State-wide fee This was only achieved schedule and obtained it by unity of action and discipline on the part of the county medical societies and physicians of the State The question now arises whether our local county medical societies should introduce and support legislation which is deemed by the Council or the House of Delegates not to be in the interest of the profession and the public. It is the opinion of your committee and of your director that the establishment of em ployers medical bureaus, such as would be permitted by the Bewley Bill, would be an entering wedge for the treatment of compensation claimants by employers and carriers and the first step in the destruction of the principle of free choice of physician by the patient under the Workmen's Compensation Law"

It was voted that Dr E Forest Merrill, who contemplates moving to Rochester, be thanked for his cooperation while acting as a member of the Workmen's Compensation Board Examining Committee

on Roentgenology

Unfinished Business

New York State Institute of Applied Arts and Sciences—The Council, on December 11, 1947, voted to table for a month application from the New York State Institute of Applied Arts and Sciences for nomination of a member of their advisory committee in order to have time to gather some informa

tion about the organization

Dr Andresen stated that he had investigated and found that it was established in 1946 by the Legislature of the State of New York, it is one of five such institutes, established at Binghamton, Buffalo, Ithaca, White Plains, and Brooklyn These are to provide education and training in applied arts, crafts, business, the subprofessions, and technical skills, including related work in arts and sciences. It is approved by the State and by the Board of Regents. He stated it would be wise to have a physician help guide this institute in directing any subprofessional technical medical training they might wish to offer

After discussion, it was voted that the chair appoint Dr Andresen to represent the State Society on the Advisory Board of the New York State Institute of Applied Arts and Sciences in Brooklyn

New Business

Dr Andresen presented the following report made by Dr Brondum, a radiologist, at a meeting of the Kings County Medical Society Committee on Public

Health

"He represented the Public Health Committee and the Brooklyn Roentgen Ray Society at a hearing held, at the request of the Commissioner of Health of the Department of Health, on the value of fluoroscopic shoe machine devices in the fitting of shoes Representatives of the medical profession, as well as representatives of manufacturers and shoe store owners, were present at this hearing. The opinion of the medical group was against the use of such devices because of the large dosage of roentgen units being delivered to the feet of individuals, because of the inadequate protection of the machines for the employees operating them, and because available

[Continued on page 554]

MEDICAL NEWS

Fellowships in Public Health Available Through State Department of Health

DR. HERMAN E Hilleboe, New York State
Health Commissioner announces the availabil
ity of fellowships for young physicians interested in
entering public health as a career
are for a portiod of two years or less, dopending upon
the qualifications of the applicant. Both field trainmag and academic training are given during the period

of the fellowship which carries with it a supend of \$3,600 per year. In addition, necessary travel and other expenses are paid, as well as tuition at a school of public health.

Application blanks and further information may be obtained by writing to Dr Franklyn B Amos New York State Department of Health Albany 1

Grants Announced for Mental Health Congress

GRANTS totaling \$50 000 to support the United States contribution to the first International Congress on Mental Health to be held in London next August have been announced by Dr Frank Fremont-Smith, chairman of the executive committee of the International Committee for Mental Hygner, New York City, sponsor of the Congress. The theme of "Mental Health and World Citizenthe

ship will be dealt with at the Congress, which will be attended by an estimated 2 000 psychiatrista, social workers and other social scientists from 46 countries (including 500 from the United States) according to Dr Fremont-Smith who added that it was planned to form a World Federation for Mental Health as a result of the Congress.

Eighty three discussion groups are at work in every part of the United States (with more than 50 groups in other countries) preparing material. Two Central Commissions have been set up in

Two Central Commissions have been set up in New York, he added, one under the chairmanship of Dr Lyman Bryson to collate material on the general theme, while the other under the chairman ship of Dr David M. Love, will report on the effect of war on children.

To carry out the work of the Congress additional

funds will be required

Industrial Health Courses at Columbia University

THE revised and expanded teaching program in inaugurated in the academic year 1947–1948 at the School of Public Health, Columbia University will be continued during the school term which starts in September 1948. Courses of study have been set up to train properly qualified physicians, nurses engineers and chemists for specialized work in industrial medicine.

Physicians may be candidates for the Master of Public Health degree with major emphasis on industrial hygiene or may work for the degree of Master of Science in Industrial Hygiene Graduate muses who have a baccalaureate degree and are otherwise qualified may be accepted as candidates for the Master's degree in Industrial Hygiene. The normal course of study occupies an academic year of eight months and students who have not had adequate practical experience may spend an additional period of from two to four months in field work.

The various curriculs are designed to give the students a broad concept of the field of industrial medicine. The courses include general background in industrial medicine, occupational diseases and toxicology industrial medical organization and

administration, lectures, demonstrations and practice in engineering and laboratory methods as well as appropriate field work.

appropriate field work.

To round out the teaching program, courses are given in biotatistics epidemiology sanitation, public health practice personnel management, public speaking, professional writing, health oducation and nutrition.

A feature of the work at Columbia is a weekly seminar in which physicians nurses, engineers and chemists meet together

In addition to the full-time curricula outlined above opportunities are available to a limited number of part time students, not candidates for a degree who may wish to caroll for individual courses each of which runs for a period of eight weeks, occupying from two to four hours a week. Physicians practicing industrial medicine in the metropolitan New York area should find this possibility particularly attractive.

Prospective students are invited to address in quiries to The Director, Columbia University School of Public Health 600 West 168th Street, New York City 32.

Vitamin May Aid Penicillin as Germ-Killer

TRRADIATED pyrido amine, a modified Vitamin B_6 is being studied for its possible killing action

against typhoid, dysentery, and other gram-negative germ organisms not affected by penicillin The studies are being made by Dr Gregory Schwartzman, of Mount Sinai Hospital, New York, under one of five grants-in-aid totaling \$28,370 announced recently by Dr Robert S Goodhart, scientific director of the National Vitamin Foundation, New York City Dr Schwartzman is also being assisted in his investigations by the Commonwealth Fund

Receiving the second largest grant from the

Foundation, Drs L J Goldwater and M E Shils, Columbia University School of Public Health, are studying the effect of pantothenic acid, member of the Vitamin B complex, on counteracting occupational poisoning

Other recipients in this State of the Foundation's grants-in-aid and their investigative projects are Dr Theodore W Oppel, the New York Hospital, \$6,100, for studies on biotin metabolism in man

Six thousand, five hundred dollars to Dr Elaine P Ralli, New York University, College of Medicine, for studies on the relation of pantothenic acid to the functions of the adrenal cortex

Research Grants and Fellowships Announced

R ESEARCH grants to three medical research institutions were renewed recently by Schering Two of the Corporation, Bloomfield, New Jersey grants provide for the appointment of fellows in endocrinology at Jefferson Medical College and the University of Oregon Medical School, and the third grant, for continued study on the enzyme hyaluronidase, has been awarded to Dr Charles Birnberg of the Jewish Hospital of Brooklyn

An endowed fellowship fund for medical research, honoring the late Philip A. Benson, has been established at the Long Island College of Medicine. Income from the fellowship of \$34,200 will be awarded on an annual basis, and will defray, in part, compensation of a man or woman selected to do investigative work in one of the College's basic science or clinical departments For many years president of the Dime Savings Bank, Mr Benson also served as a trustee of the College of Medicine for twelve years and as chairman of its finance committee

\$5,000 Donated for Epilepsy Research

A GRATEFUL father, whose epileptic son regained his health through use of newly developed drugs, has contributed \$5,000 for further research on the disease at the College of Physicians and Surgeons of Columbia University

Dr J C Price, a research associate in the Neurological Institute, where the research is conducted, said that the son figured in the initial studies that led to the development of a standard treatment of epilepsy

It is essentially, Dr Price stated, a study of new medicines that tend to control seizures, integrated into a program that enhances socio-economic reclamation of the epileptic person

MEETINGS

PAST

New York Tuberculosis and Health Association

Dr Kendall Emerson was elected president of the New York Tuberculosis and Health Association at the annual meeting January 27 in New York City Re-elected vice-presidents were Drs Edward P Eglee and Oswald R. Jones

Two new members were elected to the board of directors—Dr Norman Plummer, medical director of the New York Telephone Company, and Dr William Hunter Stearns, instructor in medicine, College of Physicians and Surgeons, Columbia

University

New York City Welfare Council

Ninety-seven of every 200 older persons admitted to mental hospitals die in the first year of hospitaliza-tion, Dr Bernard Wortis, director of the psychiatric division of Bellevue Hospital, told the meeting of the New York City Welfare Council's Conference Group on Welfare of the Aged, on January 29

Saranac Lake Medical Society

Dr D M Brumfiel was the guest speaker at the meeting of the Saranac Lake Medical Society held February 4 at the Saranac Laboratory His topic was "Incommoda Cordis Apud Incolas Eius Loci Sacpe Inventa."

Society of Medical Jurisprudence

"Artificial Insemination from Donor in Cases of Incurable Male Sterility" was the topic of a talk given by Dr Marie Pichel Warner, gynecologist and obstetrician Beth David Hospital at the meet-

ing of the Society of Medical Jurisprudence February

9 in New York City
Dr Robert S Hotchkiss, associate professor of clinical surgery Cornell University Medical School was in charge of the discussion legal aspects of the subject were presented by Mr Sidney B Schatkin assistant corporation counsel City of New York, and psychiatric aspects by Dr Sarah R. Kelman, associate neurologist and psychiatrist, New York Post-Graduato Medical School

FUTURE

Niagara Falls Academy of Medicine

The Niagara Falls Academy of Medicine will hold its annual Clinical Day on March 6 in Ningara Falls.

The program for the day includes the follow ing speakers and topics Dr George Crile "The Present Status of Propyl Thiouradi and Surgery in the Treatment of Hyperthyroidism Dr William Bates, professor of surgory, Postgraduato School of Medicine, University of Pennsylvania, The Simulation of Thoracic and Abdommal Viscoria Pathology by Sogmental Neuralgia, and Dr Foster Kennedy The Allergio Influence in Management

Dr Maurice Chideckel will be guest speaker at

the evening banquet.

New York Diabetes Association

With Dr Herman O Mosenthal as presiding officer an open meeting of the New York Diabetes Association will be held March 19 at 8 30 PM. at Hosack Hall New York Academy of Medicine. Feature of the program will be a review of studies on blood sugar by Dr Edward T Waters, associate professor, department of physiology University of Toronto Discussants will include Dr Frederick M Allen, professor of diseases of metabolum, New York Polyclinic Medical School and Hospital Dr Edward S. Dillon president of the American Diabetes Association Dr Thomas H McGavack, professor of clinical medicine, New York Medical College and Dr Charles H Best director de-partment of physiology University of Toronto

PERSONALITIES

Celebrated

Dr Grosvenor S Farmer Watertown, who was 98 years old on January 6 now retired from active medical practice known as dean of the North Country's medical fraternity and the oldest living graduate of St Lawrence University graduated in 1871 and from New York Homeopathic College in 1874 practiced in Gouverneur and in Watertown.

Honored

Dr Walter W Palmer, Bard professor of medi-cine at the College of Physicians and Surgeons, Columbia University who will rotite this spring honored by presentation of portrait of him, painted by Robert Brackman, to the College a gift of staff members friends and fellow physicians.

Appointed

Dr Clarence E. de la Chapelle associate dean of New York University College of Medicine, as direc tor of medicine at Lenox Hill Hospital has been for 15 years chief of the hospital s cardiovascular service and clinic Dr William H do Rouville. action and climic Dr whitam H do Rouvillo, assistant attending surgeon Albany Hospital and assistant professor of surgery, Albany Medical College as chief surgeon of the Deleware and Hudson Raliroad Dr Paul R. Gerhardt, former director of division of cancer control West Virginia State Health Department State Health Department as director of cancer control on the staff of the New York State Department of Health Dr J Murray Steele, associate professor of medicine, New York University College of Management of the New York University College of Management of the College of Management of the College of Management of the College of Management of the College of Management of the College of the Coll of Medicine as full professor of medicine at the Col legs and director at Goldwater Memorial Hospital

Elected

Dr Conrad Berens New York City, as president of the Pan American Association, at the third Pan American Congress of Ophthalmology held in Havana Dr Max Dannenberg, doctor of radiology at Both El and Brooklyn Womens Hospitals, as president of the East New York Medical Society

Speakers

Dr Donald A. Covalt, associate professor of rehabilitation and physical medicine, New York University School of Medicine at a meeting of volunteer women assistants trained by the New York State Association of Occupational Therapy, February 3 in New York City Dr Cornolius P Rhoads, director Memorial Hospital, New York City who gave the fifth laity lecture on Perspectures in Cancer Research at the New York Acad City who gave the fifth laity lecture on 'Perspec-tives in Cancer Research at the New York Acad emy of Medicine, February 4 Dr T J C Van Storch, neurologist at the Albany Hospital who described a study of the brain by use of a machine which amplifies electrical currents, at a meeting of the Monarch Club in Albany on January 27 Dr Violet Kiel Bronxville, as a member of the panel on Station WFAS, White Plains, on January 4, discussing "Should We Have Compul sory Health Insurance?"

New Offices

Dr John Kalamarides, formerly of Flushing, general practice in Hannibal Dr Arnold M. Wlesen, Army veteran and formerly EENT chief at the Regional Station Hospital Fort Belvoir Virginia, practice of EENT at Riverhead

HOSPITAL NEWS

Roosevelt Hospital Conforms to Council's Master Plan

THE Hospital Council of Greater New York has begun the implementation of its Master Plan and has designated Roose elt Hospital as a "participating hospital" in the Plan, it was announced in February in the Council's Bulletin The Master Plan is defined by the Council as a flevible guide for the integration and development of hospital and health facilities in relation to the needs of the people

Reviewing the plans of hospitals conforming to the basic principles of the Master Plan, the Bulletin said, "it is fitting that Roosevelt Hospital be selected" By the terms of the will of James H Roosevelt, signed in 1854, "the hospital was incorporated through the cooperative efforts of individuals with responsibilities in the fields of medical education and hospitals. Under this cooperative atmosphere the cornerstone of Roosevelt Hospital was laid in 1869"

The review of the plans and program of Roosevelt Hospital, on which the Council's designation was based, revealed that the hospital plans replacement facilities for the reception and emergency departments, and also for the outpatient department. In addition, the hospital plans for the establishment of facilities for a maternity service, which the Council has stressed in its reports as necessary in every general hospital.

Roosevelt Hospital, it was stated, has at present 410 beds, of which 230 are for ward patients, 93 are for private, and 87 for semiprivate patients. An approved school for nursing also is located on the

site

Extensive rehabilitation of facilities has been in progress during the past eight years. The size of the hospital, the report added, will not exceed 600 beds

Hospital Diets Subject for Institutes

THE TWO institutes on hospital dietary departments scheduled for April by the American Hospital Association will be held in Buck Hill Falls, Pennsylvania, April 19 to 23, and in Kansas City, Missouri, April 12 and 13

Emphasizing the place of the dietary department in the total hospital service offered to the community, both institutes are designed to help administrators work closely with their dietitians in establishing sound and efficient departmental organization with resultant attractive, well-planned patient meals

The five-day institute at the Buck Hill Falls Inn

in Pennsylvania, "Modernization of Food Service Facilities and Procedures in Hospitals," will cover three important phases of dietary administration good personnel organization and training, modernization of facilities and layout and departmental controls and costs, and the educational responsibilities of the hospital An open forum is planned on hospital in-service training of the dietitian

on hospital in-service training of the dictitian

This institute is sponsored by the Hospital
Council of Philadelphia, Hospital Association of
New York State, Greater New York Dictetic Association, Philadelphia Dictetic Association, and

Teachers College, Columbia University

Roswell Park Memorial Institute Makes Policy Changes

PATIENTS suffering from beingn hemangiomata will no longer be accepted at Roswell Park Memorial Institute in Buffalo, according to a recent announcement by Dr Louis C Kress, Institute director

The change in policy was inaugurated, Dr Kress said, because such patients no longer present a diagnostic or research problem and can be treated by practicing physicians and dermatologists throughout the state

Approximately one fifth of the case load of the dermatologic department of the Institute consists of benign hemangiomata, which are not malignant, but require time which might be devoted to patients with cancer, according to Dr Kress

NEWS NOTES

The first cancer-prevention clinic devoted exclusively to teen-agers was opened in February at the Kate Depew Strang Prevention Clinic, a division of Memorial Hospital Center for Cancer and Allied Diseases, New York City The clinic will be an

extension of one which was opened a year ago for children up to fourteen years of age

Dr Selman Waksman, discoverer of strepto-

mycin and professor of antiblotics Rutgers University, began a series of forums in the auditorium of Jewish Sanitanum and Hospital for Chronic Diseases, Brooklyn on February 4. His subject was 'The Past Present and Future of Antibiotics.''

Dr Paul Lussheimer spoke on "The Neurotic Personality of Our Time at a meeting of the Brooklyn State Hospital Psychiatric Forum on February 5

The Children's Aid Society, New York City consumed recently that it had ninety two beds available for children recovering from rheumatic fover and that in the last two years 578 children were cared for at the society's Elizabeth Milbank Anderson Home for Convalescent Children Chappagua, and the Milbank and Martha Homes for Convalescent Boya, Valhalla. The society accepts rheumatic fever and general convalescent children the recommendation of doctors visiting nurses, hospital social service departments and other social agencies

Dr William P Longmire Jr associate professor of surgery at Johns Hopkins Hospital Baltimore delivered the 1948 William Linder Vlemorial Lecture of the Jewish Hospital of Brooklyn, February 11 His topic was "Recent Advances in Chest Surgery"

In line with the policy of continued education for doctors the medical staff of Wychoff Heights Hospital Brooklyn, on January 13 heard lectures by two members of the department of chemistry and physics of St. John's University Professors Harold A. Horan and Ernest G Theroux. Their topic was 'Recent Developments in Chemistry and Physics'in Relation to Hospital Practices

A health program for Chenango County has been proposed by Dr. Ralph M. Vincent, district state beath officer to the county Board of Supervisors Prepared by the New York State Department of Health and the Joint Hospital Survey and Planning Commission, the health prospectus would provide for a unified county health department, for the expansion of a public health laboratory to be located in the Chenango Momorial Hospital in Normich for additional 70 hospital bods and a chronic unit of 63 beds, expanding the hospital to 130 beds establishment of two state-aided public health centers

and the eventual construction of a new 50-bed hospital in the southern part of the county

Dr Harold G Wolff associate professor of medicine and psychiatry at Cornell University Medical Collego, spoke on 'Protective Reaction Patterns in Man Involving the Organs of Alimenta tion as the first Isidoro W Held Lecture at the Beth Israel Hospital on February 25

Twelve Queens hospitals were among the 3 143 institutions that have been approved by the American College of Surgeons in its thirtich annual standardization, it was announced recently in Chicago. They are Flushing Hospital and Dispensary Flushing, Illislide Hospital Bellerose, St. Joseph s, Far Rockaway Jamaica, Mary Immaoulate Queens General and Triboro all in Jamaica. St. John s. Long Island City, Creed more State Hospital Queens Villago, Rockaway Beach Hospital and Dispensary. U. S. Naval Hospital St. Albans and St. Anthony's, Wood haven

Western New York's first complete unit for the care of premature bables was opened recently at Children's Hospital Buffalo The unit, furnished with the latest equipment and staffed with especially trained personnel has a capacity of 22 beds and is divided into four nurseries and autility room. The unit will be invaluable also as a training center for doctors nurses, and hospital administrators and will provide a basis for the study of the cause of promature birth, according to Dr Mitchell I Rubin, Children's Hospital pediatriclan. The new wing is a gift of 'a friend of the hospital who has long realized the need in this area for such specialized care.

Brunswick Hospital and Home Amityville has been converted into a general hospital according to a recent announcement from the hospital's new owners.

The hospitals will be open to all doctors in the vicinity of Nassau and Suffolk counties who are in good ethical standing, the owners said. The new directors of the hospital are Dr Hyman B Hendler and Dr Bon M Stein, of Hempstead Dr Jack M. Lesnow and Dr Charles J Preefer, Rockville Centre and Dr Sidney S Hein Garden City Dr Convas L. Markham, who has been superintendent of Brunswick Hospital since 1910 is remaining in that capacity

PERSONALITIES

Elected.—Dr Charles L Reigi Stapleton member for the last thirty years of the surgical staff of St. Vincents 4 Hospital Richmond, as president of the hospital's medical board, succeeding Dr Donato V Catalano Dr Enrico C Soldini Stapleton, as vice-president of medical board St Vincents Hospital, and Dr J Goller Silver Lake, as board

secretary As chief of staff of Albany Hospital Dr Thomas O Gamble professor of obstetrics at Albany Medical College and chief obstetrican at the hospital As vice-chairman of the Albany Hospital staff Dr Otto Faust, and as scretary treasurer Dr John F Filippone Dr Donald R Reed as [Continued on page 554]

NECROLOGY

Charles Hume Baldwin, M D, of Utica, died on January 26 at the age of seventy Prior to his retirement, Dr Baldwin was consultant in orthopedic surgery to the Little Falls Hospital, and the Faxton, St Luke's, and St Elizabeth hospitals in Utica was graduated from Harvard Medical School in Dr Baldwin was a Fellow of the American 1904 College of Surgeons and a member of the Oneida County and New York State medical societies

Oscar Henry Bohm, M D, seventy, who had practiced medicine in Yonkers for forty-six years, died He received his medical degree in on January 29 1901 from Columbia University, College of Physicians and Surgeons Dr Bohm was a member of the Yonkers Academy of Medicine and the Westchester County and New York State medical so-

Robert Brittain, MD, of Downsville, died on January 3 He was eighty years of age and had been a practicing physician for more than fifty years Dr Brittain was graduated from Albany Medical College in 1890, began his practice in Shavertown, and moved to Downsville in 1896 He was a member of the American Public Health Association, the Delaware County Medical Society, the American Medical Association, and the New York State Medi-

cal Society

Arthur Smith Chittenden, M D, of Endicott, died on January I at the age of seventy-five ceived his medical degree from Johns Hopkins Medical School in 1900 and practiced in New York City before returning to Binghamton in 1909 Chittenden was a former consultant at Wilson Memorial Hospital, Johnson City, Ideal Hospital of Endicott, and Binghamton Hospital He retired in 1934 His interest in the use of x-rays in medical treatment led to the founding of the Kilmer Pathological Laboratory and Binghamton City Hospital's maternity building Dr Chittenden was a member of the New York Academy of Medicine, the New York State and Broome County medical societies, and the American Medical Association

also a Fellow of the American College of Surgeons Anna M Grove, MD, of Greensboro, North Carolina, formerly of Yonkers, died on January 28 She was eighty years of age and was graduated from the Woman's Medical College of the New York In-firmary in 1892 Since 1893 she had been a member of the faculty of Woman's College of the University

of North Carolina in Greensboro
Arthur Otto Hahl, MD, of Clarence, died on
June 17 He was fifty-six years of age Dr Hahl was graduated from the University of Buffalo, School of Medicine, in 1908 He was affiliated with the Millard Fillmore Hospital, Buffalo Dr Hahl was a member of the American Medical Association, the Erie County and New York State medical societies

Thomas Howell, M D, of New York City, died on January 24 at the age of seventy-nine He was superintendent of the New York Hospital from 1909 to 1935 and head of its outpatient department since From 1935 to 1942 Dr Howell was director of the Overlook Hospital, Summit, New Jersey was assistant director of the New York Hospital-Cornell Medical College Association, and in 1913-1914 he was president of the American Hospital Association He was also a member of the New York and New Jersey hospital associations and the

Minnesota State Medical Association Dr Howell received his medical degree from the Dartmouth Medical School in 1895

Charles Edward Lane, M D, of Poughkeepsie, died on December 27 He was ninety-two years of He was graduated from the New York Homeopathic College in 1883 Dr Lane was consulting physician at Vassar Brothers and St Francis hos-

pitals in Poughkeepsie

Morris J Lavine, M D, of Syracuse, died on November 8 He was fifty years of age He was graduated from Syracuse University, College of Medicine in 1919, and interned at Mt Sinai Hos-pital in New York City Dr Lavine was on the staff of the Onondaga County Home and Hospital in Syracuse He was a member of the American College of Radiology, the Academy of Medicine, and the New York State and Onondaga County medical societies

John Alexander McCreery, M D, of Greenwich, Connecticut, formerly of New York City, died on January 31 He was sixty-two years old ating from Columbia University, College of Physicians and Surgeons, in 1910, Dr McCreery was on the staff of Bellevue Hospital until World War I, when he went to Europe with the Presbyterian Hospital Medical Unit, becoming director of surgery of AEF General Hospital No 2 Resuming practice in New York City after the war, Dr McCreery was associate clinical professor of surgery at Columbia University until 1925 From 1925 to 1940 he was director of the First Surgical Division at Bellevue Hospital Going to the Greenwich Hospital as director of surgery, he became the hospital's chief of staff two years ago

Dr McCreery was a founding member of the American Board of Surgery and a Fellow of the New York Academy of Medicine, the American Surgical Society, and the American College of Surgeons was president of the New York Surgical Society from

1945 to 1947

He was consulting surgeon to Bellevue Hospital, United Hospital, Port Chester, and the Stamford and St Joseph's hospitals in Stamford, Connecticut

Norbert Neumann, M D, of Ridgewood, Queens, died in January He was thirty-five years of age Dr Neumann was graduated from the University of Vienna in 1936 He was a member of the New York State and Queens County medical societies, and the American Medical Association

Charles F Roche, M D, of Miami Beach, Florida, formerly of Montauk, Long Island, died on January

17 at the age of fifty-nine

De Mont Ryan, M D, of Dryden, died on October 25 at the age of seventy-two He was graduated from Syracuse University, College of Medicine, in He was a member of the American Medical Association, and the New York State and Tompkins County medical societies

Edwin Heddon Shepard, M D, of Syracuse, died He was sixty-nine years of age on December 26 and had been a practicing physician in Syracuse for forty-one years He was graduated from Syracuse University, College of Medicine, in 1904, and then took postgraduate courses in Berlin, Munich, and at St Bartholomew Hospital, London He was chief

[Continued on page 554]

WOMAN'S AUXILIARY

TO THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

Convention Committee Meets to Complete Plans

WITH preliminary reports already received from the chairmen of the various committees work ing on the annual convention of the Woman's Auxiliary to be held May 17 to 21, 1948 at the Hotel Pennsylvana, New York City the general chairmen are urging all who plan to attend to make their hotel reservations immediately

The program for the convention includes registration, meetings of the executive board and the House of Delegates, a luncheon county presidents conference and the joint banquet with the State

Medical Society

Committee chairmen representing various county societies, are Mrs. Clitton L. Dance, general chair man Kings Mrs. William J Lavelle cochairman, Queens, Mrs. Joseph F Worthen, acknowledg ments Richmond Mrs Myron Hafer dinner Suffolk, Mrs F E. Elliott, flowers, Kings Mrs. Thomas M D Angelo, headquarters, Queens Mrs. George P Bergmann hospitality Suffolk Also Mrs John L. Neubert information, Nas sau Mrs. Vincent J Tesoriero lunchoon Lings

Mrs Joseph D Hallinan junior ushers Queens, Mrs. Watter J Puderbach, printing Kings Mrs. Harold Foster supplies Queens, Mrs. Edwin A. Griffin, publicity Kings Mrs Michael M Schultz, registration and credentials, Queens Mrs. Fred Jones finance, Oneida, Mrs. John J Goller tickets, Richmond Mrs. Alfred M Mudden, resolutions Albany Mrs. Charles E Scofield, house of and Mrs. J T Mckoever, memoriam, Orange

A meeting of the convention committee was held

December 1 in Brooklyn.

Scottish Newspaper Tells Story of Auxiliary Gift

FEATURED in the December 21 1947 issue of The Sunday Post, tabloid newspaper published in Glasgow, Scotland is a two-column story telling of candy and goodies supplied children of Oban Scotland as a result of the gift of money made by the Woman a Auxiliary at the annual convention in Buffalo last May

With the headline, "These Doctors Wives Could Scarcely Believe Their Eyes!—They Saw Our Daily Ration and They Acted' the newspaper story reports the talk given by Mrs. Alan E Cameron, of Oban on "A Housewife Looks at Postwar Britain at the 104 annual convention. Describing how the housewives of Scotland were living. Mrs. Cameron gave a graphic portrayal of the limited food supplies showing the Auxiliary members a tray with the small amounts which make up an individual s daily food ration in Scotland.

According to The Sunday Post Until then, these American women had no conception of how we were living, asys Mrs. Cameron. They had a vague idea that if we were not getting much meat we must be dreadfully sick of eating chicken! They did not appreciate that when we are short we are practically without!

They were particularly impressed by the fact that little children had so few sweets So at their meeting the following day the delegates voted funds and added personal contributions to be given to Mrs Cameron to provide a treat for the kiddles in recognition of the very real sympathy aroused among members of the organization.

Mrs. Cameron completed arrangements for the candy to be forwarded, and it was distributed among the four Oban schools prior to the Christmas

holidaya.

COUNTY NEWS

Albany County

Members of the Albany County Woman's Auxiliary were active during the Christmas season when they aided in the annual Christmas seasons when they aided in the annual Christmas seasons are a Christmas party at the Albany Hospital for incurables at which gifts and refreshments were distributed, and were in charge for one day of the sale of articles made by the blind.

At their December meeting, somiannual reports of the officers and committee chairmen were pre-

mented.

On February 25 the group sponsored a legislative dinner meeting at the Hotel Wellington,

Albany with Mrs William McThomson, county prosident, in charge. Dr Robert Hannon, legis-lative chairman for the Medical Society of the State of New York, spoke, and guests included Mrs Harry F Pohlmann State Auxiliary president Mrs. Edgar Noptune president-elect of the State Auxiliary and Mrs. Alfred P Grussner State legislative chairman.

In March, the Albany County Auxiliary is spon soring a solver tea for the benefit of the Red Cross. to be held at the home of Mrs. Emerson Crosby Kelly

In April the group will celebrate its tenth an niversary as an organization,

Allegany County

Dr D H McMann, Hornell, district health officer, spoke to members of the Allegany County Woman's Auxiliary when the group met in November The president, Mrs John F Glosser, Wellsville, reports that the unit is contributing to the Physicians' Home and is interested in the Angelica County Home

Meeting on January 8 at the Wellsville Country Club, the group discussed the Wagner-Murray-Dingell Bill and read and discussed Dr Haven Emerson's "Ten Point Plan," which was sent to all

newpapers in Allegany County

On March 11, the Auxliary has been invited to have dinner with the Allegany County Medical Society at Belmont, when Dr Louis Kress, director of the Roswell Park Memorial Institute and charman of the executive committee of the New York State Cancer Society, will speak to both groups The technicolor film on cancer, "The Traitor Within," will also be shown

Through the efforts of Dr and Mrs Edward Briggs, a cancer picture was shown to the Rotary

Club of Wellsville

In September, the Auxliary went on record as unanimously in favor of the county health unit Although the plan was defeated on February 3, the members have announced that they will continue to work for the county health program

Mrs Edward Comstock, chairman of the "shutins" committee, has reported that the Tuberculosis Association will work with the Auxiliary on the project of collecting and selling articles made by the

"shut-ins"

Cattaraugus County

Carrying out the plan to work with the county Parent-Teacher Associations in presenting information on rheumatic fever and heart disease, Mrs Maurice G Sheldon, Olean, Auxiliary president, during January attended five meetings in the county Accompanying her were Mrs Ronald F Garvey and Mrs N P Johnson, both of Olean, members of the committee

Mrs Sheldon reports that the P-T A.'s have done an excellent job in getting a large attendance at each meeting, for which Mrs Sheldon appoints a local doctor's wife as chairman. The County Health Department has loaned a screen and projector, and, so far, over 900 have seen the film and recording, "Jimmie Beats Rheumatic Fever." More meetings are planned for the spring

Radio time at the local station has been arranged, with recordings supplied by the American Medical Association, and a fraternal order in Olean has adopted the project of raising funds for research on

rheumatic fever

On February 12, members of the Auxiliary and the County Medical Society held a joint meeting in Olean to hear Dr. Herbert H. Bauckus, Buffalo, speak on socialized medicine, and Mr. Thomas E. Walsh, field representative of the State Society's Public Relations Bureau, speak on the chiropractic bill.

Chenango County

Chenango County Woman's Auxiliary was organized by Mrs Herman W Galster, Scotia, state organization chairman, at a meeting December 11 in Norwich. Officers elected were Mrs John C Lee, Norwich, president, Mrs James M Flanagan, Norwich, vice-president, Mrs 8 M

Nichter, New Berlin, secretary, and Mrs W D

Mayhew, Oxford, treasurer

Present to assist in the formation of the new group were Mrs Harry F Pohlmann, Middletown, State president, Mrs Edgar M Neptune, Syracuse, State president-elect, Mrs M M Monserrate, Binghamton, sixth district councillor, and Mrs John J Buettner, Syracuse, president of the Onondaga County Woman's Auxiliary

Clinton County

Elected as Clinton County Auxiliary's first officers are Mrs Edwin Sartwell, Peru, president, Mrs Andrew Z Speare, Chazy, vice-president, Mrs Franklin Atwater, Plattsburg, secretary, and Mrs George Temple, Keesville, treasurer

At the next meeting, Mrs Sartwell will appoint committees, and the group will plan future activi-

ties

Columbia County

Mrs Harry F Pohlmann, State Auxiliary president, was guest speaker at the luncheon meeting of the Columbia County Auxiliary, held February 24 in Hudson. Presiding was Mrs Ralph F Spencer, Claverack, county president

Dutchess County

Self-education is Dutchess County Auxiliary's theme for the year The president, Mrs Archibald W Thomson, Poughkeepsie, with the guidance of Mrs J Emerson Noll, Port Jervis, second district councillor, is making plans for the unit

Erie County

A Christmas tea was held December 16 in honor of the Erie County Auxiliary's 43 new members and several prospective members

A study group has been organized and held its first meeting January 12 in Buffalo, under the leadership of Mrs Thomas F Houston, legislation chairman Mrs Arthur L Bennett, Buffalo, is Erie president

Fulton County

Main project of the Fulton County Auxiliary is to collect medical and surgical supplies to be sent to the center in New York City, where they will be shipped overseas for the relief of needy countries, in accordance with the plan sponsored by Admiral William Halsey

The January meeting was held at the home of Mrs Robert Kunkle in Gloversville, with Mrs Harry F Pohlmann, State president, as guest speaker Describing the activities of other auxiliary units, Mrs Pohlmann gave suggestions for further projects and asked for aid for the Physicians' Home

For the February meeting, at the home of Mrs Arthur Wilsey, Gloversville, election of officers and

a revision of the constitution was planned

Greene County

District Councillor Mrs Albert Vander Veer, Albany, spoke on "Legislation" at the meeting of the Green County Woman's Auxiliary, held February 24 at the Catskill Country Club, Catskill

Kings County

Dr Milton J Senn, child psychiatrist, Cornell University Medical School, spoke at the January meeting of the Kings County Auxiliary, held following a buffet lucheon

[Continued on page 552]



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ANNOUNCEMENTS

THE UNIVERSITY OF THE STATE OF NEW YORK THE STATE EDUCATION DEPARTMENT BOARD OF MEDICAL EXAMINERS

Dr W P Anderton, Secretary Medical Society of the State of New York, 292 Madison Avenue New York 17, NY

Dear Dr Anderton

This is to notify you that the Board of Regents at a meeting held November 21, 1947,

Voted. That the determination of the Medical Committee on Grievances in the matter of the application for the revocation of the medical license heretofore granted to Harry Lowens, Washington, DC, be accepted and sustained, that, in compliance with the recommendation of said committee, said Harry Lowens be censured and reprimanded, that said Harry Lowens be ordered to appear for such censure and reprimand before the Board of Regents at a time and place to be determined by the Commissioner of Education, notice of which shall be given to said Harry Lowens by said Commissioner, and that the Commissioner of Education be empowered and directed to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote

Dr Lowens has not registered since 1941 with the Department. He is now located at 808 Quintana Place, NW, Washington, DC The order was served on Dr. Lowens by registered mail on December 5, 1947

> (Signed) JACOB L LOCHNER, JR., M D, Secretary N Y State Board of Medical Examiners

December 15 1947

To the Secretaries of the Medical Boards of the United States

Gentlemen

This is to notify you that the Board of Regents at a meeting held November 21, 1947,

VOTED, That the determination of the Medical Committee on Grievances in the matter of the application for the revocation of the medical license heretofore granted to Anne Elizabeth Kuhner, New York, be accepted and sustained, that, in compliance with the recommendation of said committee, medical license No 17809, issued under date of June 28, 1923, to said Anne Elizabeth Kuhner, permitting her to practice medicine in the State of New York be revoked, annulled and canceled, and that her registration or registrations as a physician, wherever they may appear, be ordered annulled and canceled of record, and that the Commissioner of Education be empowered and directed to execute, for and on behalf of the Board of Regents, all orders necessary to accept the determination of said Committee on Grievances and to carry out the terms of this vote

Dr Kuhner was registered for the years 1947–1948 from 52 Gramercy Park North, New York City The order was served on Dr Kuhner on December

5, 1947, and the medical license therefore stands revoked as of that date

> (Signed) JACOB L LOCHNER, JR, MD, Secretary NY State Board of Medical Examiners

January 6 1948

Dear Dr Anderton

This is to notify you that the Board of Regents at a meeting held November 21, 1947,

VOTED, That the determination of the Medical Committee on Grievances in the matter of the application for the revocation of the medical license heretofore granted to Edward N Morgan, Huntington, West Virginia, be accepted and sustained, that in compliance with the recommendation of said committee, said Edward N Morgan be censured and reprimanded, said Edward N Morgan be ordered to appear for such censure and reprimand before the Board of Regents at a time and place to be determined by the Commissioner of Education, notice of which shall be given to said Edward N Morgan by said Commissioner, and that the Commissioner of Education be empowered and directed to execute for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote

Dr Morgan has not registered with this Department since 1941 He is now located at 600 12th Avenue, Huntington, West Virginia The order was served on Dr Morgan by registered mail on December 5, 1947

> (Signed) JACOB L LOCHNER, JR, MD, Secretary NY State Board of Medical Examiners

December 15, 1947

To the Secretaries of the Medical Boards of the United States

This is to notify you that the Board of Regents at a meeting held October 17, 1947,

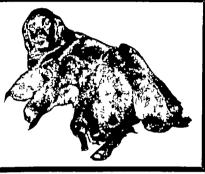
VOTED, That, pursuant to the provisions of subdivision 1 of section 6514 (formerly section 1264) of the Education Law, medical license No. 11341, issued under date of September 20, 1912, to Leopold W. A. Brandenburg, Union City, New Jersey, permitting him to practice medicine in the State of New York, be revoked, annulled and canceled, and that his registration or registrations as a physician, wherever they may appear, be ordered annulled and canceled of record, and that the Commissioner of Education be empowered and directed to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote

Dr Brandenburg was never registered for the practice of medicine in the State of New York. His present address is 2802 Hudson Boulevard, Union City, New Jersey The order of the Commissioner

[Continued on page 552]



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Announcements

[Continued from page 550

was served on Dr Brandenburg on November 25. 1947

> (Signed) JACOB L LOCHNER, JR, MD, Secretary NY State Board of Medical Examiners

January 6 1948

To the Secretaries of the Medical Boards of the United States

Gentlemen

This is to notify you that the Board of Regents at a meeting held May 16, 1947,

Voted, That the determination of the Medical Committee on Grievances in the matter of the application for the revocation of the medical license heretofore granted to Gaspare Genova, Brooklyn, be accepted and sustained, that, in compliance with the recommendation of said committee, medical license No 20128, issued under date of January 28, 1926, to said Gaspare Genova, permitting him to practice medicine in the State of New York, and his registration or registrations as a physician, wherever they may appear, be suspended for a period of one year from the date of service of the order effecting such suspension, and that the Commissioner of Education be empowered and directed to execute, for and on behalf of the Board of Regents, all orders necessary to accept the determination of said Committee on Grievances and to carry out the terms of this vote

Dr Genova was last registered with the Department in 1936 from 1257 70th Street, Brooklyn, New The order of the suspension was served on June 4, 1947, but due to litigation the suspension did not go into effect until December 11, 1947 (Signed)

JACOB L LOCHNER, JR, MD, Secretary NY State Board of Medical Evaminers

January 6 1948

To the Secretaries of the Medical Boards of the United States

Gentlemen

This is to notify you that the Board of Regents at a meeting held November 21, 1947,

VOTED, That the determination of the Medical Committee on Grievances, in the matter of the application for the revocation of the medical license heretofore granted to Boris Schleifer, Brooklyn, be accepted and sustained, that, in compliance with the recommendation of said committee, medical license No 18479, issued under date of June 26, 1924, to said Boris Schleifer, permitting him to practice medicine in the State of New York, be revoked, annulled and canceled, and that his registration or registrations as a physician, wherever they may appear, be ordered annulled and canceled of record, and that the Commissioner of Education be empowered and directed to execute, for and on behalf of the Board of Regents, all orders necessary to accept the determination of said Committee on Grievances and to carry out the terms of this vote

Dr Schleifer was registered for the years 1947-1948 from 2001 Strauss Street, Brooklyn, New York The order of the Commissioner was served on Dr Schleifer on December 3, 1947, and his medical heense is revoked as of that date

JACOB L LOCHNER, JR., M D , Secretary NY State Board of Medical Examiners January 6 1948

Woman's Auxiliary

[Continued from page 548]

On February 29, a benefit cocktail party for the Physicians' Home was held, with Mrs D A Ajello, Mrs Vincent Teseriero, and Mrs Richard Walsh acting as hostesses

Celebrating the thirteenth birthday of the Auxillary, a luncheon will be held March 9 at the Gramercy Park Hotel, New York City, in honor of Mrs John L Bauer, founder and first president of the group, who will receive a scroll signed by the charter members, and the title of Honorary President for life Guests who have been invited include Mrs Harry F Pohlmann, Mrs Luther Kice, and Mrs Edgar M Neptune, State officials, Mrs Daniel Swan, Queens County, Mrs Myron Hafer, Suffolk County, and Mrs William G Miller, Nassau County

On April 13, the annual meeting and election of officers will be held Mrs Charles E Scofield is

president-elect

Onondaga County

Featuring, in the Christmas spirit, plans for giving summer camperships, the Opendaga County

Auxiliary, of which Mrs John J Buettner, Syracuse, is president, held its annual holiday lucheon in December in Syracuse Carrying out their annual custom, 80 members brought gifts and money to be distributed by the Christmas Bureau, a clearing-

house for giving to needy families

Guests at the meeting were Mrs Harry F
Pohlmann, State president, and Mr Paul K.
Weinandy, director of Huntington Club Settlement House, who thanked the group for the 7 two-week camperships the Auxiliary gave last year

Queens County

The first 1948 executive board meeting of the Queens County Auxiliary was held January 20 at the home of the new president, Mrs Daniel J Swan The guest speaker, Dr Alfred Angrist, president of the Queens County Medical Society, urged the group to continue its support of the Queens County

Medical Library
Mrs Adrian Donnelly, Flushing, membership
chairman, has announced that the 15th anniversary of the Auxiliary will be celebrated at a tea on March

16 to which all doctors' wives are invited.



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Minutes of the Council

[Continued from page 540]

orthopedic opinion was against the usage, feeling that the machines were of no particular value. The manufacturers contended that the dosage was not excessive, and there was adequate protection because the employees have been trained in their use. The lawyers countered with the widespread use of dental x-ray machines but were told that in dental x-ray one assumes that there is sufficient indication to warrant its use but not so in the fitting of shoes. The dangers to physicians and patients as a result of exposure to x-rays in an uncontrolled manner was stressed by the medical representatives.

"Dr Brondum felt that such use of fluoroscopic machines may lead to the promiscuous use of these machines for fingers, lungs, etc, and he spoke of the long-term dangers to the employees who are using large amounts of x-ray and radium in industry, and of the problem of disposal in hospitals using large

amounts of radioactive materials He offered the following motion, which was approved

"It is suggested that the Public Health Committee consider the installation of a Subcommittee on Radiologic Safety, whose function it would be to give advice, to correct such abuses of radioactive materials, and to act as an educational group to the medical profession as to the dangers to which the public are being subjected ""

Dr Andresen thought we should have a similar

Dr Andresen thought we should have a similar subcommittee of our State Public Health and Education Committee

After discussion, it was voted to refer this report to the Public Health and Education Committee subject to the judgment of Dr Mitchell as to its disposition, and whether or not to have a special subcommittee for consideration of problems relating to radioactivity and atomic energy

Hospital News

[Continued from page 545]

president of the medical staff of Tarrytown Hospital, Dr Milton E Johnston as vice-president, and Dr Eugene Saberski as secretary-treasurer

Appointed.—Dr John J Morton, Jr, of the University of Rochester, School of Medicine and Dentistry, as a member of the National Advisory Cancer Council of the National Cancer Institute, US Public Health Service To the staff of the Canan-

daigua Veterans Administration Hospital, Dr Andrew Fergus, from the Binghamton State Hospital

Dr Walter Igersheimer to the New Haven Unit and Dispensary from the Jewish Hospital of Brooklyn As assistant in pathology at St Vincent's Hospital, Richmond, Dr Alberto Montoya, formerly assistant pathologist at Mt Sinai Hospital, New York City

Necrology

[Continued from page 546]

examiner for the Travelers Insurance Company's Syracuse branch and examiner for the New York Telephone Company in Syracuse for forty years Dr Shepard was a member of the Onondaga County Medical Society, the New York State Medical Society, and the American Medical Association He was also a member and past-president of the Syracuse Academy of Medicine

James Cornelius Sullivan, M D, of Buffalo, died on February 2 at the age of fifty-nine Graduating from the University of Buffalo, School of Medicine, in 1910, Dr Sullivan was on the faculty of the medical school and was attending surgeon at the Buffalo General, Children's Deaconess, and Lafayette General hospitals

He was a member of the Academy of Medicine, the New York State and Erie County medical societies, and the American Medical Association He was also a Fellow of the American College of Surgeons

Victor C Thorne, M D, of Greenwich, Connecticut, formerly of New York City, died on January 18 He was seventy-six years of age After graduating from the Sheffield Scientific School of Yale University in 1894 and the Columbia University Law School in 1896, Dr Thorne received his medical degree from the Cornell University Medical School in 1900 He practiced in New York City and was associated with the New York Hospital prior to his retirement twenty years ago

Jacob B Young, M D, of Barker, died January 2 at the age of eighty-five He was graduated from the University of Buffalo, School of Medicine, in 1900 For thirty-one years he practiced in the Black Rock and Riverside sections of Buffalo, retiring sixteen years ago because of poor health

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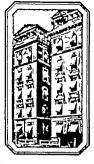
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Size of Articles -It is earnestly desired that scientific articles shall not exceed 6 Journal pages Longer articles tend to lower reader at the outside An average of five or six seems to be the most desirable from this point of view Calculation can readily be made by multiplying the number of double-spaced typewritten manuscript pages by the fraction two-fifths, e g, twelve manuscript pages will make five Journal pages

Manuscripts —Papers must be typewritten on one side only of white sheets consecutively numbered, and be double spaced with one-inch margins. They should be prepared with great care so as to be typographically correct All headings, titles, subtitles, and subheadings should be typed flush with the left-hand margin This is imperative for rapid and accurate composition by the printers

Titles —The title should be brief and typed in capital letters. The subtitle can be longer and should be typed in caps and lower case letters Under the title, or subtitle, if there is one, should appear the name of the author and city in which he lives Directly under his name should be the hospital or institution with which he is affiliated

Subheadings —Subheadings should be inserted by the author at appropriate intervals

References —It is the unfailing practice of the New York State Journal of Medicine to use specific "references" rather than "bibliography" There should appear in the text reference numbers, typed above and to the right of the word to which there is a reference —A list, consecutively numbered, of these references should follow at the end of the manuscript. (Note that spelling in list is some as in manuscript (Note that spelling in list is same as in text) The arrangement should be as follows and should include all items

Books—author's surname followed by initials, title of book, edition, location and name of publisher, year of publication, volume, and page number Thus, Osler, W Modern Medicine, 3rd ed , Philadelphia, Lea & Febiger, 1927, vol 5, p 57

Periodicals—author's surname followed by initials, name of periodical, volume, page, month (day if necessary), year of publication Thus, Leahy, Leon J New York State J Med 40 347 (March 1) 1940

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Case Reports —Instead of abstracts of hospital histories, authors should write these reports in a narrative style with properly completed sentences All unimportant details should be deleted with such general negative statements as fit the case

Tables —While tables are very useful on lantern slides in the reading of papers, they fail of this pur-pose to a large extent in the printed page—For that reason it is urged that they be reduced as much as possible to descriptive language

Illustrations —These should be kept to the minimum necessary to make clear the points to be registered by the author In some instances they are imperative to proper understanding, in others they are merely picturesque. The latter can be excluded to good effect, both as to space and the not inconsiderable cost

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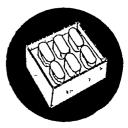
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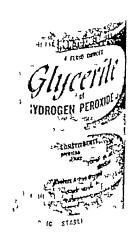
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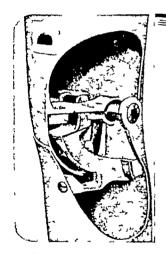
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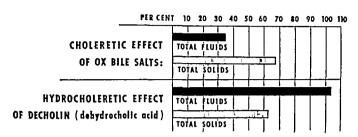
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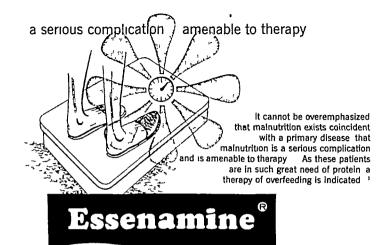
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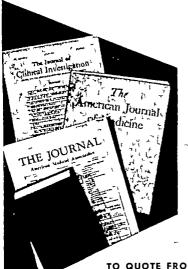
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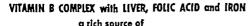
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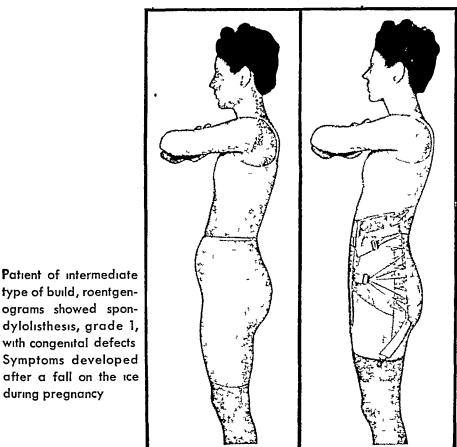
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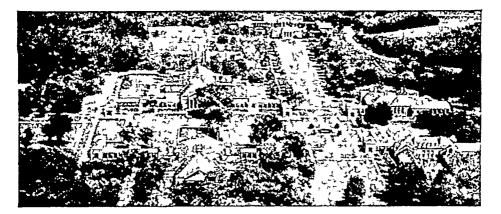
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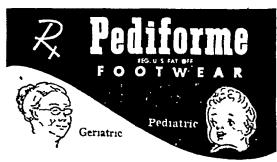
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eruly feeces it is a r - ត្រាដ្ឋមេ ប្រជា t liment copyrio medita Surperior divident com.plete' (kŏm.plēt'; 2), adj. [L. completus, past part of complere to fill up, fr. com-- plere to fill 1. Filled up; with no part lacking. <

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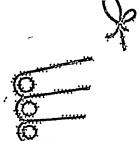
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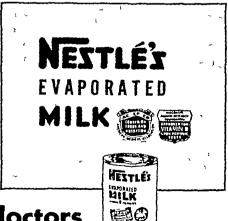
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(Carrell, C., and Allen, H. N; The Treatment of Uniany Infections with Mandelamine (Methemanius Mandelate); A Cilcient Study of 200 Cases. J Urol. 88: 674-681 (June) 1846.

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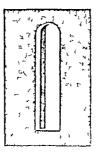


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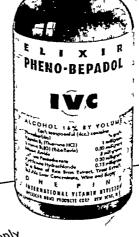
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For adults, use the same dosage as that recommended for oil-wax preparations For infants, 0 2 cc (60,000 units), children up to ten years, 05 cc (150,000 units), and children over ten years, 1 cc (300,000 units)

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Editorials

Cancer Diagnosis

The public has been exposed to extensive propaganda on the subject of the early diagnosis of malignancy as the essential item in the reduction of a disease which is the dread of mankind Millions of dollars are collected annually to support a campaign for research and detection The National government also has supplemented such research with huge sums No doubt, mass efforts to arouse an appreciation of the attendant dangers to life of a malignant process may be necessary and perhaps desirable, but the resultant cancer-phobia which has developed is an unfortunate accompaniment. Women in particular are affected because so much attention has been centered on their special organs. Unfortunately, the subjective symptoms which bring them to a physician may be those of a far-advanced stage of the disease, and, hence, more radical measures may be necessary than if the process had been diagnosed in its earlier phases

Numerous investigators have given their time and thought to methods for detecting cancers of the uterus and the cervix in their incipiency Papanicolauo, in the belief that such cancers give rise to exfoliation,

developed a procedure for collecting the cellular debus, and by special stains the components could then be identified However, as stated in a first report, in 1941, the interpretation of the smear required "the services of a careful and discriminating cytologist—few persons can be depended on for this work at the present time," Although these investigators admitted that they failed to detect the characteristic ma lignant cells in a small number of cases of demonstrated cancer, others who have in vestigated and studied the method have experienced less favorable results and have hesitated to recommend operative measures unless the cellular diagnosis was confirmed by a biopsy specimen. 2 3

Naturally, in our democratic medical field, when any doctor proposes something new or novel, the proposal is subjected to the acid test of confirmation by other investigators. But before the results of the latter are published, the "special" or "free lance" writers associated with some of our popular magazines pick up the original sugestion before it is fully proved and develop it into a lund, and often exaggerated,

article for consumption by avid readers For instance, a certain Clive Howard, writing for the Woman's Home Companion, refers to the cystologic test for cancer of the uterus as a method, "inexpensive, painless, and at least 97 per cent accurate If put into general use, it may almost wipe out this form of cancer" 5

The subject is well-discussed in a recent editorial which appeared in the Journal of the American Medical Association (January 31, 1947) In this editorial, attention is called to a critical article by two Philadelphia investigators, Scheffey and Rakoff, who found that in a study of 500 consecutive cases, including 63 proved cancers, positive smears were obtained in 70 per cent, in other words, 30 per cent were missed ⁵

It must be admitted that no one method

of diagnosis or even of treatment can be considered 100 per cent perfect and entirely satisfactory, but it is evident that this particular procedure, as in other cases, has its limitations. We do not have in mind any desire to decry the discoveries of Papanicolauo and the others who have developed a probably valuable diagnostic procedure. It is the exaggeration which is deplorable, particularly when it develops as a "message of hope" to possibly afflicted women. All in all, the indiscriminate employment of the test, and that without competent interpretation, may do more harm than good

1 Papanicolauo G N, and Traut, H. F Am. J Obst. & Gynec 42 193 (1941)
2 Mcigs, J V Surg., Gynec. & Obst. 77 449 (1943)
3 Block, F B Am. J M. Sc. 208 794 (1947)
4 Howard C Woman & Home Companion (Oct.) 1947
5 Scheffey L L. and Rakoff A E Philadelphia Med. 43 435 (1947)

Problems in Artificial Insemination

Artificial insemination as applied to human beings poses serious questions of law which should be understood by all physicians. One such question has been decided in a New York court, namely, the status and rights of the child and of the husband when other than the husband's semen was employed in the fertilization of the mother. As reported, the decision is quoted in part

Justice Greenberg said in his ruling from the bench "The Court has assumed for the purpose of its disposition that the plaintiff in this case was artificially inseminated with the consent of the defendant and that the child is not of the blood of the defendant. This child is not illegitimate"

Mrs —— had sought to prevent her husband from visiting her child after she had won a separation from him last October on the ground that the baby was the result of artificial insemination through another man

Since physicians will be queried by their patients in instances where such procedures are contemplated, it is highly important that they keep themselves informed of the questions of law involved. As the result of propaganda, inseminations with a donor's semen are no longer infrequent. Perhaps we may assume that the maternal instinct among women cannot be satisfied in any other way, although this assumption perhaps cannot be justified by the accepted rules of civilized conduct and the marriage rite. To quote further from the decision of the eminent jurist

Justice Greenberg said he expressed no opinion "on the propriety of procreation by the medium of artificial insemination," pointing out the court was not concerned with such matters. Nor was he passing on the legal consequences, in so far as property rights are concerned, in a case where the wife has been artificially inseminated with the husband's consent. He said that the propriety of procreation through artificial insemination "is in the field of sociology, morals or religion"

¹ New York Times (Jan. 14) 1948, p 27

We repeat, the public derives its information on medical matters largely from daily newspapers, magazines, the radio, and by word of mouth Not always, unfortunately, but often, the people will check suchinformation with their family physician To encourage this practice it is incumbent upon all physicians who have, of course, access to their professional sources of information, to read these carefully

The editors of the JOURNAL attempt to bring to the notice of all members of the Society significant news relating to as many aspects of medicine as possible in the hope that well informed doctors in the innumerable communities of the State can thereby function, in their individual contacts with their patients, as reliable sources of information on topics which have frequently been suggested to them for inquiry by what they have read in the sources mentioned above. All this may seem trite, perhaps, but the development of modern technics in medicine has, as in this instance, a very important and far reaching impact on society, extending beyond the technics themselves

Another contribution to this subject is an article by B Fain Tucker, J D, commented upon in the New York Herald Tribune, from which we quote as follows

The New York Supreme Court held legitimate a child produced by artificial insemination with the consent and knowledge of the husband, in the second case on record involving this modern medical procedure. An article by Miss B Fain Tucker, of the Illinos Bar, published in the spring 1947, issue of The Women Lawyers Journal, reported that the whole body of law on the subject consists of one Canadian case, Oxford vs. Oxford, 49 Ontario Law Reports (1921)

In the Ontario case the wife frigid at the time of marriage sued her husband for alimony alleging that after a temporary separation he had refused to receive her as a wife The husband countered with a charge of adultery, alleging that his wife had given birth to a child by another man. The wife admitted the birth of the child but declared the pregnancy had resulted from artificial insemination.

The Supreme Court of Ontario did not believe her story but stated that if the in-

New York Herald Tribune (Jan. 18) 1948.

semination had been "artificial," as alleged, the wife had been guilty of adultery

The contention by the wife's lawyer that it was not adultery for a married woman to produce a child by artificial insemination secmed to the Ontario judge "a monstrous conclusion."

That was in 1921—before the practice had become more than a medical curiosity. There are now, it was testified has week, 20,000 "test-tube" children in the United States This can hardly be a statistical figure. The actual number, perhaps larger, perhaps smaller, is not known since neither physicians nor the couples involved publish the facts

More complicated legal questions may arise, the article in *The Women Lawyers Journal* made clear Some of these might involve the physician himself Court action might, for instance, hinge on such issues as the following

Did the doctor obtain the written consent of both husband and wife to the procedure, after making sure the husband was not fertile and fully explaining to the couple the social and legal complications of the contemplated step? Did he make sure that the donor was physically and mentally fit to father a child of the wife?

In a later editorial we expect to comment further on the controversial subject of artificial insemination. The often laudatory propaganda conveyed to the public through various media should not be accepted with out due thought being given to the compli cating factors which may attend this procedure, especially from a heterologous donor It is not merely the success of a technic which must be considered, it is the aftermath which is to be borne in mind not limited to legal difficulties, there are other consequences of perhaps greater significance and importance Moreover, we might well question the decision of the honor able justice that "this child is not illegitimate."

If not, we should revise, necessarily, our conception of illegitimacy. The question is not an academic one. With the growing recourse to the production of the "test-tube baby," are we to set aside all our preconceived notions of propriety and decency? Can we not overcome these so-called "psychologic demands" of women by some other means?

Moreover, a rather pertinent question arises in this connection. Assume that the husband is pronounced fertile and the wife sterile. This reverses the picture and the extreme view could be taken that the husband's desire for progeny likewise might be satisfied through extraneous sources.

Should not he be accorded an equal privilege? We pose this question and not in a spirit of facetiousness. We await an answer, and we direct the question particularly to those women who feel that they should be given a right which presumably is withheld from their married partner.

Current Editorial Comment

Important Information for Doctors Physicians of New York State are hereby warned through the courtesy of the inspection service of the Post Office Department that the old "Spanish Swindle" has been revived and that new sucker lists containing the names of numerous doctors of the State are being used

The "Spanish Swindle" consists of a letter emanating from Mexico and addressed to the putative physician-sucker. A sample letter, furnished us by the Post Office Department, is reproduced herewith for your

information

Mexico City, Mexico December 16, 1947

Mr Jonathan A Doe St Edward, Nebraska USA

Dear Sir

A person who knows you and who has spoken very highly about you has made me trust you a very delicate matter of which depends the entire future of my dear daughter, as well as my very existence

I am in prison, sentenced for bankruptcy, and I wish to know if you are willing to help me to save the sum of \$375,000 00 U S Cy (Three Hundred and Seventy Five Thousand Dollars) which I have in bank bills hidden in a secret compartment of a trunk that is now deposited in a Custom house in the United States

As soon as I send you undentable evidence, it is necessary for you to come here and pay the expenses incurred in connection with my process so the embargo on my suitcases can be lifted, one of which suitcases contains a baggage check that was given to me at the time of checking my trunk for North America and which trunk

contains the sum above said To compensate you for all your troubles, I will give you the THIRD PART OF SAID SUM

Due to serious reasons which you will know later, please reply via AIR-MAIL. I beg you to treat this matter with the utmost reserve and discretion. Fearing that this letter might have gone astray and not reach your hands, I will not sign my name until I hear from you, and then I will entrust you with all my secret. For the time being I am only signing "M".

Due to the fact that I am in charge of the prison school, I can write you like this and entirely at liberty

I cannot receive your reply directly in this prison, so in case you accept my proposition, please air-mail your letter to a person of my entire trust who will deliver it to me safely and rapidly. This is his name and address

Sr Jose Cueto Calle de Donceles #40 Mexico City, Mexico

We warn all physicians who receive such a letter or any variant of it to take it immediately to the nearest post office and turn it over to the Postmaster Do not answer, the letter Under no circumstances send any money

Get the letter immediately to your Postmaster or send it to Mr J W Hartwell, Office of Inspector, Post Office Department, Albany, New York It is not yet known, we are advised, how widespread the swindle is Several physicians in the Buffalo area have received and sent to the Postal Inspection Service such letters

All who read this are requested to pass the

information on to other doctors

Scientific Articles

MANAGEMENT OF GASTRIC HEMORRHAGE

ALBERT F R ANDRESEN, M.D., Brooklyn, New York

(From the Long Island College of Medicine)

IN treating a patient with a gastric hemor-rhage, it is well to recognize the patient as an individual, requiring individual care Yet while there is danger in treating all patients according to some stereotyped routine procedure, it is also very important to recognize that there are certain fundamental principles involved which govern every case. Before treating the case as one of gastric or duodenal hemorrhage, it is essential that other causes of hematemesis and melena have been ruled out Blood from the mouth nose, or throat, swallowed while the patient is asleep and vomited on awaking may simulate gastric hemorrhago. Bleeding esophageal lesions, especially varices, are often confused, and even small intestinal ulcerative lesions may produce both hematemesis and melena. Blood dyscrasias jaundice, vicarious menstruation, severe toxemia and even malingering must be ruled out Bleed ing from the stomach or duodenum may not be due to peptic ulcer, but to severe gastritis, neoplasms, syphilis, rupture of a sclerotic artery purpura, or allergy

Symptomology and Diagnosis

A small amount of surface bleeding occurs with any ulcer, but gross bleeding recognized by vomiting of bright red, liquid, clotted or partly digested blood, may vary in quantity. If not vomited, blood passing through the digestive canal becomes black, and even as small a quantity as 60 cc. will produce a small tarry stool. A tarry stool is one which is not only black in color but sticky and tarry in consistency. Frequently patients will not notice blood in vomitus or may ascribe the red color to recently ingested tomatoes or beets, and even more frequently a tarry stool will not be observed, being described simply as loose.

If the amount of blood lost has been under 300 cc. there may be few, if any general symptoms accompanying it. With more severe hemorrhages, however, the general symptoms have often been ascribed to a "heart attack," or the vomiting and diarrhea to a "ptomaine poison-

ing" with severe toxemin. In most cases dizziness weakness to the point of fainting, chilliness and cold sweat occur accompanied by nausea and the vomiting of blood, followed sooner or later by the passage of a tarry stool

Symptoms of shock vary with the amount and duration of the hemorrhage and may become quite alarming, being accompanied in severe cases by the symptoms of anoxia, with air hunger as the most startling phenomenon. A day or two after the hemorrhage, pallor becomes more or less marked, and the patient feels generally weak and tired. A history of previous ulcer symptoms is important when obtained, but, not infrequently, hemorrhage is the first sign of an ulcer. History of previous hemorrhage may be obtained in 30 per cent of cases. In the absence of ulcer symptoms careful study is indicated to rule out some of the other sources of bleeding.

Physical examination is important but must be conducted with extreme caution in order to prevent recurrent bleeding. The eye grounds may show arteriosclerone or renal changes, the mouth, nose, and throat should be checked for bleeding points, the chest for possible bleeding lesions, and the heart for possible decompensation, causing congestion. In the abdomen the presence of tumors or an enlarged liver and spleen must be ruled out, and rectal and pelvic examinations should be made to discover possible lesions.

Endoscopic examinations, more liable to excite bleeding should be deferred until later when esophagoscopy may be necessary proctoscopy dearable Gastroscopy, performed after roent-genologic study, may at times disclose small erosions not otherwise recognizable.

Fractional gastric analysis, using histamine as an excitant of gastric secretion, had best be deferred until ten days after active bleeding has apparently ceased. If no bleeding is demonstrated by this method complete roentgenologic study should be instituted in order that the lesion causing the bleeding be recognized as soon as possible.

Blood counts will show an increasing anemia for the first few days as blood volume is increased by absorption of fluid from the tissues Blood urea

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nitrogen is apt to rise to from 30 to 50 mg per 100 cc during absorption of the products of digestion of blood and often proves to be a valuable indication of continued bleeding, as it should begin to go down to normal within three or four days. A leukocytosis may be a danger signal, suggesting possible perforation, a severe infection, or a necrotizing neoplasm

Blood pressure readings also may be valuable indications of continued bleeding. Occasionally dropping as low as 60 and 70 mm systolic, or in previously hypertensive patients to 120 or 130 mm systolic, with low pulse pressure, it usually ceases to go down when bleeding stops and starts to climb a few days later

Indications for Treatment

Treatment is the most important desideratum when a gastric hemorrhage has occurred and should be started at once. The indications for treatment, applicable to bleeding from an ulcer, can be applied to bleeding from any other source, although it is worthwhile to rule out other causes whenever possible, so that, if present, suitable specific treatment can be applied to them. This would include the tying off or cauterization of bleeding vessels and the use of coagulants where indicated. In bleeding from ulcer the indications for treatment will be discussed in turn.

The bleeding results from a vessel, either cut across transversely or eaten out laterally, or, more rarely, may result from general surface bleeding due to congestion, to granulation of the ulcer base, or to surrounding erosions obvious that any increase in the quantity or pressure of blood in the bleeding vessel may prevent organization of a clot and cause recurrent bleeding The alternate tonic contractions and atonic periods, incident to hunger, would also tend to aggravate or reinstitute bleeding The gastric juice tends to attack the vessel and clot, allowing free bleeding Any irritants taken into the stomach, as well as the ingestion of ice, by causing hyperemia, would also have a similar effect. It is, therefore, important (1) To keep the patient at rest, if necessary aided by mild sedation, (2) To avoid too large a fluid intake, either orally or parenterally, (3) To keep in the stomach at all times a food substance (gelatin) which shall be smooth and coagulant and which should combine readily with gastric juice, (4) To avoid stimu-

The bleeding will then cease spontaneously unless the bleeding vessel is held in a mass of horny induration at the site of an old chronic (or perforated) ulcer—Such cases usually have been considered fatal in nearly every instance whether or not surgery was instituted, since operation usually necessitated an extensive procedure be-

cause of the friability of the tissues A treatment used successfully in several such cases is described below

Shock, a prominent symptom in most cases, is a conservative mechanism to produce the desired rest, hypotension, and lowered blood volume and should be treated conservatively by rest, by moderate warmth to the extremities, by psychologic care, and by sedation only as indicated Parenteral injection of fluids, even of blood, should be avoided if possible, and stimulants are usually unnecessary

Anova, as manifested by air hunger, falling blood pressure, and rapid thready pulse, calls for careful observation and, if not spontaneously checked, should be treated by small transfusions, 150 to 200 cc, just enough to overcome alarming symptoms. Transfusions of 500 cc or more often tend to aggravate the hemorrhage and may result in death

When 2 or 3 small transfusions fail to check the downward course, or if the patient is in extremis, continuous transfusions by the drip method, over a period of thirty to forty hours, using 6 to 8 L of blood, has been successfully used by me in 3 cases, all of whom are well today after five or six years

Anemia, which may be quite extreme, is usually overcome spontaneously, an increase of 15 or 20 per cent in hemoglobin and erythrocyte count taking place within two weeks. However, persistent anemia, such as often results from exhaustion of hematopoietic substances in the body as a result of repeated massive transfusions, with resultant hemorrhages, may require transfusions and hematinics after the first ten days

Complications must be taken care of as they occur In pylone stenosis, the treatment for hemorrhage is conservative, although operation may be necessary later In perforation, immediate operation, of course, is indicated

In closing, I will reproduce the "Routine for Gastric Hemorrhage Cases" which with occasional modification has been the standard for the gastro-intestinal service at the Long Island College Hospital for many years

The suggested diet, consisting of gelatin added to a high caloric liquid diet or, in cases where patients are allergic to milk or are at first nauseated by it, with fruit juices and glucose, will be first described, followed by the routine suggestions for care and medication

Routine in Gastric Hemorrhage Cases

- Order gastric hemorrhage diet
- 2 Treat shock by rest, warmth to extremities, and sedatives, if required.
- 3 Quiet apprehension. Reassure the patient Do not isolate

4 Do not take a detailed admission history nor make a complete physical examination Do no more than rule out complications or bleeding from causes other than ulcer

 Order blood coagulation tests coagulation and bleeding time, prothrombin time, vitamin K determination, and platelet count. If coagulation is

impaired, prescribe congulants

6 Type and match blood for transfusion. No transfusion to be used in first ten days except for evidence of severe anoxia. Then try 1 or 2 transfusions of 150 to 200 co of citrated blood. If not successful, prepare for continuous drip transfusion to be used until bleeding stops or at least for thirty-six hours (may require 6 to 8 L of blood).

7 Chart blood pressure every two hours at first blood urea nitrogen every two days at least

8. Test all stools for occult blood until this disappears

- 9 Start mineral oil 1/2 ounce, every night after second night. Retention oil enema on fourth night and thereafter as required.
- 10 Do fractional gastric analysis on about the twelfth day in uncomplicated cases
- 11 Start x rays on about the fourteenth day if bleeding has stopped

12 No gastroecopy until after x ray

- The following treatments and conditions should be studiously avoided
- 1 Ice Externally, increases shock. Internally, stimulates gastric circulation.
- 2 Parenternal fluids generally increase blood volume and pressure and cause more bleeding Small transfusions may be required in severe anoxemia. (See Routine.)
- 3 Stimulants (digitalis, adrenalin, etc.) Tend to increase bleeding Only used in emergency
- 4. Alkalis Stimulate secretion. Irritate bleeding area
- 5 Excitement or worry Increase shock, and reaction may increase bleeding
- 6 Examinations manipulations, or treatments Only if absolutely necessary, especially in first few days.

GABIRIC HEMOBRHAGE DIET

Gelatin-Milk Feeding.—Milk, cream and dex tross are mixed together and kept in the refrigerator Gelatin, at the rate of 50 Gm. per liter of the mix ture (Table 1) or approximately 75 Gm per day, kept in a paper cup at the bedside, is to be added at each feeding as follows

A rounded teaspoonful is to be dissolved in 1 or 2 ounces of warmed milk mrature and this is added to remaining cold mixture, making a cool palatable drink. If the petient profers it, the drink may be warmed A little flavoring (tea, vanilla, cocca) may be added at time of feeding if desired

Routins —For the first four days after the hemor rhage, feed 6 ounces of muture every two hours nothing else by mouth. If saleep the patient should not be disturbed for three or four hours

On the fourth, fifth and sixth days add to 3 or 4 of the feedings one of the following 1 egg soft boiled posched, or raw cercal, 3 ounces custard, jello or

TABLE 1 -FORMULA FOR GELATIN MILE FREDINGS

Food	Amount	Carbo- hydrate	Protein	Pat	Calorim
Gelatin Dextrose Cream	50 Gm. 60 Gm.	60 Gm.	45 Gm.		180 240
(20 per cent) Milk	100 ea. 900 ec.	3 Gm. 30 Gm.	3 Gm. 27 Gm.	18 Gm. 27 Gm.	180 850
		99 Gm.	78 Gm.	45 G m.	1 150 per L.

ice cream, 3 ounces, and allow water in 3 ounce quantities between feedings

On the seventh and eighth days, add 2 of above foods to each feeding

On the ninth day, order ulcer diet.

Gelatin-Water Feeding—Water dextrose, and orange juice are mixed together and kept in the refrigerator Gelatin, kept in a paper cup at the bedside, is to be dissolved in a part of the warmed mix ture (Table 2) as in the case of the milk mixture, or merely stirred into the mixture at the bedside.

This regimen is for patients who cannot tolerate the milk-gelatin feedings or who are allergic to milk.

TABLE 2.—FORMULA FOR GELATIF-WATER PERDINGS

Food Gelatin Dextrose	Amount 50 Gm. 90 Gm.	Carbo- hydrate 90 Gm.	Protein 45 Gm.	Calories 180 360
Juice of 3 oranges Water	to 1,000 es.	30 Gm.		120
		120 Gm.	45 Gm.	660 per L.

Routine —For the first two days after the hemornings, feed 4 ounces of the mixture every one and a half hours, the patient not to be disturbed more often than every three hours if salesp

After the second day if the patient is not really allergic to milk, the gelatin-milk routine should be followed. If the patient is allergic to milk, proceed

as follows

On the third and fourth days give 6 ounces at a feeding, every two hours, adding a teaspoonful of a protein diaysate or amino add preparation to each feeding. If the patient tolerates it well, add egg cereal, jello, or stewed fruit to 3 or 4 feedings per day (as in gelatin-milk routine)

On the auth, seventh and eighth days add 2 of

above foods to each feeding.

On the ninth day order ulcer diet, with no milk or milk products.

Vitamin C, 0.5 to 10 Gm per day, should be ordered with either routine diet.

It will be seen from a study of the above routine that in the case of the gelatin-milk feedings, a patient taking 9 or 10 feedings per day will be consuming nearly 2 000 calones in twenty-four hours with about 100 Gm. of protein. In the case of the gelatin-water feedings only 1 000 calories will be taken, with only about 60 Gm. of protein represented by the gelatin alone, or more if the patient can take a protein mixture.

In cases of pyloric stenous associated with hemorrhage I have followed the routine above in every detail, but with gentle aspiration of gastric residue once, or rarely twice, in twenty-four hours in order to prevent overdistention of the stomach. In every case the patient was benefited, whether the stenosis was relieved during the course of the treatment or whether it persisted in spite of it. In the latter cases gastric tone had been partly restored by the small feedings, making subsequent operation more successful. When the stenosis subsided, having been due only to inflammatory edema and induration about the ulcer, the ulcer due could usually be started on the tenth day or soon thereafter, preferably after an x-ray check-up

ULCER DIET

Our regular ulcer diet is started after the preliminary feedings of the gelatin mixtures and is kept up usually for six weeks thereafter when additions can be made to it gradually

The regimen is as follows

Breakfast

Milk 8 ounces

Cereal 5 ounces, with sugar and milk or cream Egg 1, soft boiled or peached

Bread or toast with butter, 1 or 2 slices Fruit juice 4 ounces (at end of meal)

Midmorning

Milk 8 ounces, always with crackers, bread and butter, or cake or

8 ounces of milk-gelatin mixture

Luncheon

Milk 8 ounces

Baked or mashed potato or plain spaghetti Egg 1, soft boiled or poached, or cream cheese Bread and butter, 1 or 2 slices

Pudding, custard, gelatin, ice cream, or stewed fruit

Midafternoon

Same as midmorning

Supper

Same as breakfast or luncheon

At bedtime and at two and one-half-hour intervals in night if awake feedings same as between meals

General

Cream and glucose may be added to feedings if patient is under normal weight

Olive oil 1/2 ounce, 3 times a day, before meals

Water ad lib

Salt not restricted

Vitamins added as required

Mineral oil if required, 1/2 ounce at bedtime

It must be remembered, above all, that each patient must be treated as an individual, and modifications of the suggested procedure may be necessary, especially in the presence of complications

88 SIXTH AVENUE

ANNOUNCEMENT

Section on Radiology, Quiz Program

Quiz Program to "stump the experts," using x-ray film, at the Annual Meeting, May 20, 1948, 10 A M

Please send problem films in which a diagnosis has been established, with brief résumé of relevant information, to

Dr Marcy L Sussman Mt Sinai Hospital 1 East 100th Street New York 29, New York

Do not send diagnosis

Identify your material carefully so that it may be returned

PRIMARY RESECTION FOR CANCER OF THE LOWER BOWEL

HARRY E BACON, MD, FACS, and ROBERT J ROWE, MD, Philadelphia, Pennsylvania

R EFINEMENTS in surgical technic, coordinated treatment prior to, during, and following operation, with coincident improvement in anesthedia, have placed the management of the lower bowel malignancy on a plane of unprecedented security

Our discussion deals with a group of 560 pa tients with malignancy of the sigmoid, rectum and anus (Table 1)

TABLE 1 - DISTRIBUTION OF MALIGNANCY

Location	Number	Percentage
Sirmold	74	12 8
Rectosigmoid	169	29 8
Rectum	203	54 9
Anus	303 14	2 5
_		
Total	560	100

The histologic type of tumor was reported as shown in Table 2

TABLE 2.—DISTRIBUTION OF HISTOLOGIC TUMOS

Adenocarcinoma	54398 8 per cent
Epithelioma Bouamous Bassi	9
Fibrosareoma.	3
Leiomyonareoma Neurogenio sarcoma	
Total	560

The moderne of node metastass in a group of 67 cases was 36.2 per cent According to location, the incidence is shown in Table 3

TABLE 3.-INCIDENCE OF METABLES IN 67 PATIENTS

Location	Number of Cases	Node Metastassa, Per Cent
Sigmoid Rectorigmoid Rectum Anal Canal	13 14	60 63 3 44 1
Squamous Basal	4—87 1 0 0	50

In a group of 146 cases in which the removed specimen of bowel was sectioned scrally at 2, and 6 cm below the growth, invasion was observed in only 1 instance at the 6 cm level Consistent with these findings, the conclusion may be made that the sphincter musculature may be preserved, providing the lower margin of the cancerous growth is at least 6 cm. distant from the anal margin. In this series the incidence of venous invasion was 129 per cent.

Cancer of the lower bowel does not cast its ominous shadows by any pathognomonic or characteristic symptoms. The average period it ime between the onset of symptoms and the examination was nine and seven tenths months

examination was nine and seven tenths months

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Section on Surgery May 9 1947

It is of interest to note that bleeding was cited in 470 patients (856 per cent) Seventeen patients suffered 1 or more hemorrhages, and in 3 cases hospitalization for transfusion of blood was found necessary

Change in bowel habit is a symptom-complex to be highly respected. Increasing constipation and the increasing need for laxatives was cited in 310 patients (53 7 per cent) Diarrhea, which is poorly representative, was described in 178 (317 per cent) The "false urge" to empty the bowel with the expulsion of flatus is significant and was noted by 212 patients (37.8 per cent) Incompleteness of evacuation was mentioned by 235 (41.9 per cent) Early morning diarrhea was complained of by 95 patients (16 9 per cent), while the passage of pencil-shaped stools was cited in 27 (4.8 per cent) Sensory disturbances referable to the bladder, prostate, or urethra were mentioned by 46 (8.2 per cent) sigmoidal lesions, where abdominal discomfort and distress tend to dominate the clinical picture. variants of pain occurred in 55 per cent which is comparable with the report of Rosser, namely, 61 per cent. In our group of patients the cancerous growth was palpated in 77 5 per cent and visualised sigmoidoscopically in 89 6 per cent

It may be of interest to mention that our associate, Dr George Broad, reviewed 161 consecutive case records of patients, subjected to abdommoperineal resection or excision, in which the extirpated bowel specimen was carefully examined *Recent specimens in this group were inspected by Dr Alexander Hering with the magnifying lens. Of the 161 resected specimens of bowel, 51 patients, or 31 6 per cent, showed adenomatous polyps in addition to the primary cancer, and of the 51, 10, or 19 6 per cent, were malignant.

The technical management of lesions of the rectum and agmoid ceases to be a moot question, as a result of the histologic investigations of Westhues, Fischer, Dukes, Coller, and David 18-14

Our approach to the problem has been to individualize each patient and to select the procedure to which he or she is best fitted. In this series of 560 patients, 520 were operated upon, giving an operability rate of 90.2 per cent, 467 were resected—a resectability rate of 80 1 per cent, with a mortality from resection of 5 5 per cent (26 deaths) It may be mentioned that we have performed radical resection in 145 patients by various technics without a single death. Our experience with low anastomosis "resectosigmoldectomy" has been almost nil,

and primary anastomosis of the sigmoid for cancer over a Furniss, Clute, or Wangensteen Clamp has numbered only 28 from which there were 2 deaths, a mortality of 7 1 per cent

While many methods have been employed for lesions of the rectum and rectosigmoid, we have found that the establishment of an abdominal colostomy and sacrifice of the sphincter muscles is an unnecessary evil in a large percentage of To the present time we have selected and performed the technic, "abdominoperineal proctosigmoidectomy," in 317 patients, from which there were 15 deaths, a mortality rate of 47 per cent

It may be mentioned that to determine the precise location of the lesion in the bowel, the records of 180 patients were studied (Table 4)

TABLE 4 -LOCATION OF LESION IN 180 PATIENTS

Sigmoid	23		
Rectosigmoid Rectum (exclusive	5333	8 per cent	80 3 per cent total
of lower 3 cm.) Anal canal (includ-	73—46	5 per cent	So s per cent total
ing lower 3 cm. of rectum)	31—19	7 per cent	
Total	180		

Assuming that those lesions in the sigmoid are resected solely by an abdominal approach, and those in the lowest 3 cm of the rectum and the 3 cm of the anal canal are resected by a method necessitating removal of the sphincters, there remains 80 3 per cent in which the sphincters may be preserved

It should be mentioned that this single criterion has been the only means of accepting or refusing proctosigmoidectomies As evidence that this group of 317 has included extended resections under unfavorable circumstances in some instances is shown in Table 5

In previous articles, we have discussed pertinent questions such as, "does preservation of the sphincter musculature compromise radicability?" and "does proctosigmoidectomy compromise radicability?" We have also attempted an unbiased evaluation of the complications and segulae pertinent to proctosigmoidectomy the development of this method our trials have been many, but with the cooperation of all, including the departments of anatomy, chemistry, and physiology, to say nothing of our resident staff and assistants, past and present, the results There is not. have been extremely gratifying and there should never be, one operative technic Because of the many to serve for all patients methods available, there are a few to which every surgeon should have recourse At no time, however, have we in our department entertained the faintest thought that we might some day return to the Miles type of resection for each and every patient

TABLE 5 -EXTENT OF RESECTION IN 317 PATIENTS

Involvement of small bowel (resection in all) Bladder (partial cystectomy) 7 Uterus and adnexa (removed in all) 9 Appendectomy 3 Vagina (posterior wall excised in all) 9 Ureter (partial resection in all) 3 Cholecystectomy 1 Abdominal (wide excision) 1 Prostate (partial or complete resection in all) 3 Liver metastasis 33—11 6 per cen 23 Adherent to sacrum 7 Transplantation of transverse colon to anus with resection 7 Transplantation of colostomy to perineum with resection 17 Diabetes 6 Asthma 2 Bronchiectasis 0 Double malignancy of rectum and sigmoid Multiple polyposis Concurrent adenocarcinoma with lymphogranulo venerum stricture Concurrent chronic ulcerative colitis and cancer Pregnancy (3 months) 0 Total 183			
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Total 183	Operation during postparturient period	3	
	Total	183	
	···		

In previous articles, reference has been made to the low rate of morbidity following proctosigmoidectomy, for in a consecutive series of 120 cases, the average time the patient was permitted out of bed was six and six-tenths days, with discharge from the hospital in thirteen and fourtenths days 1-6 Ordinarily, patients return to work six or ten weeks after this type of resection The incidence of sexual impotence in the male is recorded as 8 3 per cent, compared to 95 per cent following the Miles operation

Our incidence of five-year cures, computed after the method of Newman of the British Ministry of Health, is 526 per cent which is based on those resected for palliation as well as for cure 7 For those patients in grade A classification according to mural penetration, the five-year survival rate is calculated in our series as 933 per cent

255 SOUTH 17TH STREET

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DIFFERENTIAL DIAGNOSIS OF ABDOMINAL TUMORS BY THE ROENTGEN METHOD

SAMUEL BROWN, M.D., Cincinnati Ohio (From the Jewish and General Hospitals)

IT IS well known that the abdomen is the most furtiful source of tumor formation. Early diagnosis is imperative if we hope to be successful in eradicating tumors from the body before invasion or metastasis sets in. The roent-gen method has greatly improved the chances of recognizing them much earlier than was ever possible by the clinical and physical findings alone.

In general, tumors originate from both within and without the gastroenteric tract. The latter group will receive chief attention in the present discussion. It may be added here that the word tumor is used in its larger sense and refers to any enlargement without reference to its exact nature.

The application of the roentgen method in the diagnosis of extragastroenteric tumors has been used since its inception, and a considerable literature has accumulated ¹⁻¹ My approach to this subject is distinguished by the fact that an attempt is made to establish a scientific basis for a diagnosis.

The abdomen contains a number of organs and attructures, occupying definite places which bear a constant relationship to each other and leave no empty space in the cavity. Thus, according to the unalterable law of nature that two bodies cannot occupy the same place, the enlargement of an organ or the presence of a new mass within the abdominal cavity will bring about the displacement or compression or both of an adjoining structure.

An analysis of the abdominal structures reveals that, according to the degree of stability, the organs are, relatively speaking either stationary such as the liver, spleen, kidneys pan creas, and gallbladder, or freely movable, such as the stomach and bowels

Regional and topographic anatomy (surgical anatomy) shows that the organs in the abdominal cavity do not lie in the same plane nor does a single organ occupy the same plane through its entire extent. It is evident, then that in order to obtain a true idea of the exact position, shape, and sire of any abdominal organ and its relation ship to other organs the abdomen must be subjected to a three-dimensional study

Heretofore, at least until recently, the roent

Presented, by invitation at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo Section on Radiology May 8, 1947 gen study of the abdomen consisted of making an anteroposterior reentgenogram which represented a two-dimensional projection, registering an accumulation of superimposed shadows of three-dimensional abdominal organs. Such a view will show alterations of the organs only in the longitudinal and lateral directions. It is evident that in order to obtain information of any changes in the anteroposterior direction a lateral projection is absolutely essential. Thus, each projection complements the other and, taken together, enable one to obtain a true three-dimensional study of each organ, and any deviation from the normal may be recognized readily

The application of the three-dimensional study of the abdominal organs reveals that in the presence of an enlarged organ or mass in the neighborhood of the stomach and bowels or both, alterations in the position, shape, or con tour may take place in the latter structures has been noted that these changes do not take place in a haphasard manner, but, in general follow certain directions, depending upon the organ which is involved and upon the position of the body as a whole Thus by certain distinguishing characteristics, it is often possible to determine with a high degree of accuracy the location and origin of the extragastroenteric tumor In general, it was found that tumors arising in the upper abdominal cavity displace the stomach and bowels downwards, whereas tumors which arise in the lower abdominal cavity cause an upward displacement. Tumors arrang in the right side displace the stomach and bowels to the left and cause displacement to the right when they arise on the left side Tumors arising medially displace the stomach to the left and the duodenum to the right. Tumors arising behind the stomach and duodenum disblace the latter forward and backward when the tumors arise in front of the stomach.

The following routine is carried out in the roentgen study of the abdomen

- 1 Fluoroscopic inspection of the chest with special reference to the position and mobility of the diaphragm. This structure is often found to be elevated in part or in whole as a result of an intra-abdominal tumor.
- 2 A plain anteroposterior projection of the abdomen is considered to be absolutely essential, for it may reveal important information as to the presence of an abdominal tumor

3 In the 4 standard horizontal positions, dorsal, ventral, right and left lateral, a roentgen study of the gastroenteric tract is made, not so much for its own sake but in reference to its topographic relationship to the neighboring organs

A brief review will be presented describing the usual location of the stomach and bowels in

the several standard positions

In the dorsal and ventral positions the stomach and duodenum lie in the left upper and middle zones, either transversely or vertically or anywhere between these 2 extremes, depending upon the habitus of the individual and the position of the body as a whole. Thus, in the sthenic type of individual the transverse position prevails, while in the asthemic the vertical position is the rule. The jejunum usually occupies the upper left side and the ileum the lower right side of the abdomen. The colon is located at the periphery with its transverse portion below the greater curvature of the stomach.

The liver is located in the right upper and middle zones, and its left lobe overlaps a good part of the stomach. The gallbladder and the extrahepatic biliary ducts he to the right of the pylorus and duodenum. The right kidney lies to the right of the spine behind the liver and descending duodenum. The pancreas extends from the duodenal loop across the spine to the spleen behind the stomach. The hepatic flexure follows along the lower margin of the liver.

The spleen is located posteriorly in the left upper zone and the left kidney below and medially. The splenic flexure of the colon is usually located below the spleen, but at times it reaches the under surface of the diaphragm.

In the right lateral decubitus position the fundus and cardiac portions of the stomach are located anteriorly with the anterior wall of the stomach almost parallel to the abdominal wall, while the posterior wall is parallel to the spine The left lobe of the liver, although in front of the stomach, produces very little compression upon the anterior wall under normal conditions In obese individuals a thick layer of fat may be present, but the normal parallelism is not upset The same applies to the posterior wall of the stomach in its relation to the spine, the distance being greater in the sthenic than in the asthenic In order to avoid misinterpretation ındıvıdual the particular habitus of the individual should always be kept in mind before a diagnosis of a retroperitoneal tumor is made

In the right lateral projection the pylorus lies between the cardiac portion of the stomach and spine with the duodenal bulb sitting on top of it. From here the course of the duodenum is backward, and at the superior angle it bends downward, paralleling the spine in front of the

right kidney and bending upward toward the left side at the inferior angle in front of the spine, below the body of the pancreas it joins the jejunum. Thus, in the lateral position the duodenum is presented in its true perspective, describing a loop within which the head of the pancreas is enclosed. The distance between the descending duodenum and spine varies, depending upon the habitus of the individual, being greater in the stheme than the astheme individual. In the latter the duodenum very often overlaps the spine.

The relationship which exists between the duodenum and the surrounding structures, namely, the stomach, pancreas, gallbladder, liver, extrahepatic biliary ducts, right kidney and colon, is quite intricate, and a knowledge of this relationship, as it is presented by the roentgen method, is quite essential in order to enable one to diagnose tumors of these structures

The superior angle of the duodenum is surrounded by the neck of the gallbladder on the right side, by the cystic and hepatic ducts above, and by the common bile duct on the left side. This tubular structure resembles a horseshoe whose open ends are directed downwards toward the head of the pancreas and gallbladder, respectively, forming an almost closed ring which practically encircles the superior angle of the Furthermore, it is re-enforced by the solid structures of the liver above, the pancreas below, and kidney behind That makes the duodenum what it is, the most fixed segment of the small bowel It is, therefore, to be expected that an enlargement of any of the neighboring structures will be reflected in the position. shape, and contour of the flexible walls of the duodenum

In the left lateral projection the direction of the stomach is, from above, downward and forward, and the degree of inclination depends upon the habitus of the individual, being almost at right angles to the spine in the sthemic individual, parallel to the spine in the asthemic individual, or anywhere between these two extremes. Again, before deciding whether there is a displacement as a result of a tumor, the habitus of the individual must be taken into consideration.

In the great majority of cases the following deductions were found to be correct

1 Displacement of the stomach and duodenum to the left and backward indicates a large liver Displacement of the stomach and duodenum to the left and forward indicates a large kidney Displacement of the stomach and duodenum to the left but neither forward nor backward indicates a large gallbladder

- 2 Displacement of the stomach and duodenum to the right and forward is due either to a large spleen, kidney, or pancreas In case of a large spleen or pancreas, the splenne flaxure is usually displaced downward which is generally not the case with tumors of the kidney If the stomach and duodenum are displaced backward, it is due to onlargement of the left lobe of the liver
- 3. Displacement or lack of displacement of the stomach and duodenum in opposite directions in the ventral position, but with forward displacement in the lateral position, indicates a retroperitoneal tumor, either pancreatic or glandular Backward displacement indicates a liver tumor
- 4. Enlargement and compression of the segment of the duodenal loop, both in the frontal and lateral projections, indicate a tumor of the head of the pancreas Enlargement of the loop in the frontal position, but with narrowing in the lateral position, may be due to a superimposed tumor from the transverse colon
- 5 Pressure defects upon the contour of the duodenum indicate a large gallbladder when the bulb is compressed Pressure defect upon the superior angle indicates dilatation of the extrahepatic billary ducts due either to stones or, more often, to tumors When the pressure defects are associated with paindice, this usually indicates the presence of the obstructive type, which is, of course, of great importance in the differential diagnosis of the nonobstructive type.

More than one abdominal tumor may affect the stomach and duodenium in different directions which at first may appear to be confusing but upon a careful analysis of the alteration which takes place in the various positions of the body one may arrive at a correct interpretation.

Conclusion

The roentgen study of the gastroenteric tract and its relationship to the neighboring struc

tures, as revealed in the above outline, has enabled us to arrive at an accurate diagnosis of extragastroenteric tumors with a high degree of accuracy

Discussion

Leo Larkin, M.D., Ithacz.—We have all been cognizant of many of those effects on the duodenum of tumors arising outside the gastrontestinal tract. I doubt whether many of us have appreciated, however the large amount of information the apeaker has been able to correlate by having a thorough knowledge of the anatomic relationship of both the intra and extraportioneal organs of the gastrointestinal tract, and by combining with this knowledge the application of good judgment and common sense in interpreting the indirect changes brought about by abnormal variations in these structures.

Dr Brown has demonstrated beyond question the great value in revealing pressure defects in the duodenum, particularly, which would be completely overlooked without the use of the right lateral decubitus position. In spite of his provious publications on the subject I think many of us have been lax in making full use of this suggested position.

In retrospect I am sure I have missed several opportunities to make a more accurate diagnosts by not using the right lateral decubitus position routinely Probably, the greatest value we could all derive from this presentation would be to adopt the use of this position in all studies of the upper gastrointestinal tract.

Today particularly, when there are so many physicians who feel they are quite competent to make their own interpretations of ordinary lesions of the gastrointestinal tract, it becomes necessary for us, as radiologists, to be able to recognize these more obscure lesions which as Dr Brown has demonstrated can be done

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THE SCHERING AWARD FOR 1948 ANNOUNCED

The interesting and vitally important subject of The Role of Hormones in the Maintenance of Pregnancy" is the basis for the Schering Award for 1948

For the three best manuscripts submitted by undergraduate students of American and Canadian medical schools on such a designated phase of endocrinology, the Schering Award annually offers cash prisos of \$500 \$300 and \$200

Through his efforts in preparing a manuscript for the competition, the medical student acquires useful information in various important fields of endocrinoloxy. The Schering Award is sponsored by the Schering Corporation of Bloomfield New Jersey.

CLINICAL EXPERIENCE WITH NITROGEN MUSTARD

W W FALOON, MD, and L W GORHAM, MD, Albany, New York

(From the Department of Medicine, Albany Hospital)

As A result of wartime research, the battle against neoplastic disease has received a new weapon, a group of drugs now known as the nitrogen mustards—Following a large amount of, as yet, unpublished work on the chemical and biologic effects of these drugs, they were released in 1946 for further clinical investigation—The preliminary trials and reports on these compounds were accomplished by Gilman and Philips, Rhoads, Goodman, Wintrobe and their coworkers, and Jacobson and his associates 1-4 At present, the work is being coordinated by the Committee on Growth of the National Research Council 5

Following World War I, there were a few reports describing the effects of mustard gas (sulfur mustards) on the hemopoietic and gastrointestinal systems $^{6-10}$ This work was extended experimentally during the recent war in preparation for defense against poison gas. This led to extensive study of mustard gas, bis(β -chloroethyl)sulfide, and its nitrogen analogues, bisand tris(β -chloroethyl)amines. The latter have become the agents of choice in this group

Briefly, these compounds can be characterized as contact vesicants and cytotoxic substances. The degree of susceptibility of cells to their action is related, in general, to the degree of proliferative activity. The action which these mustard compounds accomplish on cells can be likened to no other known chemical agent but in many ways resembles that of x-ray

The basic formula and fundamental reaction of the (\$\beta\$-chloroethyl) amines are shown in Figures 1 and 2 Essentially, the reaction is the phenomenon of intramolecular cyclization in a polar solvent, shown in Figure 2, to form a cyclic

FORMULAE

MUSTARD GAS (SULFUR MUSTARD)

SCH_CH_CI
CH_CH_CI
CH_CH_CI
NITROGEN MUSTARDS

CH_1 CH_1 CI
CH_2 CH_2 CI
CH_2 CH_2 CI
NCH_2 CH_2 CI
NCH_2 CH_2 CI
CH_2
Fig 1

"onium" cation which yields the activity of the compounds. The great reactivity of the onium cation imparts the varied actions to this group. It reacts readily with amons and various unchanged nucleophilic molecules. The nitrogen mustards are stable in strong acids which make possible their isolation in the form of hydrochlorides. However, the sulfur mustards assume the sulfonium form more readily, and its reactivity is so great that its isolation in sufficient amounts is difficult. This is merely a practical difference in obtaining the 2 types of compounds, and their physiologic actions do not differ significantly.

REACTIONS of METHYL bis (& CHLOROETHYL)
AMINE IN DILUTE AQUEOUS ALKALINE SOLUTION

$$CH_{3}-N \xrightarrow{CH_{2} CH_{2} CI} \xrightarrow{CH_{3}-N-CH_{2}CH_{2}+CI} \xrightarrow{CH_{2} CH_{2}+CI} \xrightarrow{CH_{2} CH_{2}+CI} \xrightarrow{CH_{2} CH_{2}+CI} \xrightarrow{CH_{2} CH_{2}+CI} \xrightarrow{CH_{2} CH_{2}+CI} \xrightarrow{CH_{2} CH_{2}+CI} \xrightarrow{CH_{2} CH_{2} CH_{2}+CI} \xrightarrow{H^{+}+CH_{3}-N} \xrightarrow{CH_{2} CH_{2} CH_{2} CH_{2}} \xrightarrow{CH_{2} CH_{2} CH_{2} CH_{2}} \xrightarrow{CH_{2} CH_{2} CH_{2} CH_{2}} \xrightarrow{CH_{2} CH_{2} CH_{2} CH_{2}} \xrightarrow{CH_{2} CH_{2} CH$$

A variety of alkyl groups can be attached to the nitrogen atom of the nitrogen mustard compound and therein lies the value of the drug, as in the sulfonamides, the possible chemical combinations are many, and the future will doubtless see them explored It is now known that the onium cation of the nitrogen compounds, ethylenimonium, reacts with a number of compounds of biologic importance Among these are amino acids, thiamin, phosphates, various enzymes, and proteins, such as hemoglobin, insulin, and albumin In vitro studies have shown that the mustards reduce the oxygen consumption of tissues and depress the aerobic and anaerobic glycolysis of glucose Not all the enzyme systems studied in vitro have been shown to be affected equally in vivo, however, but among those enzymes affected are hexokinase, phosphokinase, and peptidase in the serum, skin, and lung. The basic mechanism is probably through some reaction with a vital cellular constituent, but the specific chemical lesion has not been found.

The cytotoxic effects of the mustards are most marked on the lymphatic, hemopoietic, and gastrointestinal systems. The seventy of this response is in direct relationship to the dose ad ministered Among the demonstrable pathologic changes are vacuolization and nuclear swelling of the epithelial cells of the gastrointestinal tract, lymphatic fragmentation and atrophy, and a disappearance of mitotic activity Lethal doses produce death by circulatory collapse as a result of the nausea, vomiting, diarrhea, and electrolyte less which occur Bone marrow and blood studies following nitrogen mustard ad ministration have revealed production of an aplastic anemia picture with leukopenia and thrombocytopenia. Regenerating tissue shows a reduced mitotic rate and the mitotic arrest appears to be confined to the resting phase of the mitotic cycle. Chromosomal changes which are transmitted through generations in a manner similar to that produced by x ray have also been demonstrated. It should be mentioned however, that abnormalities of cell structure and function occur which are not attributable to primary nuclear intoxication For a more complete review of the basic characteristics of the mustard compounds one is referred to the paper of Gilman and Philips 1

Reported Clinical Use

In 1946, 2 reports of the clinical use of nitrogen mustard appeared which discussed the results of treatment on 126 cases of neopleatic disease 14 The work thus far has been con fined largely, to its use in Hodgkin's disease, lym phosarcoma, leukemia, and poly cythemia vera, al though scattered cases of melanosarcoma, reticuloendothelious, carcinoma of the breast, carcinoma of the cervix, giant follicle lymphoma, sympathoblastoma multiple myeloma, and undiagnosed tumors have been treated These miscellaneous diseases were, except for sympathoblastoma unaffected in the cases reported Temporary improvement was noted in 2 patients with sympathoblastoms. A recent communication from the National Research Council reports transient reliaf of symptoms in 21 of 30 cases with inoper able carcinoma of the lung. It is to be remembered that, in the cases reported the dosage varied widely and improvement in these statistics may occur with further experience. At present, however it seems that the best results are to be expected in the neoplastic diseases of the lym phatic and hemopoletic organs

Among the changes noted by the investigators

in these early series of cases were decrease in lymph nodes, sploen, and liver sue, disappearance of fever and malaise, gain in appetite and weight, and occurrence of a sense of general well-being

Albany Hospital Experience

In November of 1946, a supply of methyl bis(s-chloroethyl)amine hydrochloride was made available to the Albany Hospital It is our purpose to present at this time our experience with the use of this drug in a series of 15 patients treated in the six months since that date. These are summarized in Figure 3.*

ALBANY HE		CASES .		
	TOTAL	RESPONSE	FAILURE	DURATION of RESPONDE
HODBKINS	6	6	0	1 5
PAMONATONA	3	3	0	1 6%
CHRONIC LEURENA HYELD BEHOUS	2	•	1	0
POLYCYTHEHIA	+	+	•	
TOTAL	15	13	1	3 5

Fig 3

Methods and Material -All patients except 1 received intravenous injections on four consec utive days of 01 mg of methyl-bis(s-chloroethyl)amine hydrochlonde per Kg of body weight In order to reduce the severity of the immediate toxic symptoms of nausea and vomiting nearly all patients received the injections after an overnight fast. Three grains (0.2 Gm.) of sodium amytal were given by mouth an hour before treatment Because of marked vomiting following the first two injections, in 1 patient the treatment was discontinued for one day, and the course was then completed Because of the known vesicant property of the drug at was prepared and administered with care in order to avoid contact with the skin the person administering it wearing rubber gloves. The injection was made through the tubing of a rapidly flowing intravenous solution of normal saline in order to avoid subcutaneous leakage of the medication Because of rapid loss of activity after the pow dered drug is put into solution, the procedure is carried out within five minutes after dissolving the nitrogen mustard

All patients were followed with complete blood counts at least twice weekly for the three weeks following injection and examinations were per-

The authors wish to express their gratitude to the following for permission to study cases under their care: Dr. Richard T. Besbe, Dr. James F. Rooney. Dr. Frank Maxon, Dr. Joseph Robinson, and Dr. Kalmon Rosenblatt.

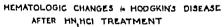
This is part of a study authorized by the Committee on Growth of the National Research Council, New York City Dr G. P Ithouds is chairman of the committee. The supply of nitrogen mustard was kindly furnished us by Merck and Company Inc., Rahway New Jersey The authors wish to express their gratitude to the follow-

formed at least once a week Most of these patients were hospitalized for fourteen to twentyone days in order to follow them closely. It is
our practice now, however, to discharge the
patients, if hematologic studies can be obtained
at home or in the outpatient department, and
providing adequate follow-up is possible outside
the hospital. After the critical initial threeweek period, patients have been seen at one- or
two-month intervals.

Thus far, 15 patients with Hodgkin's disease, polycythemia vera, lymphosarcoma, and leukemia have received a total of 19 courses of nitrogen mustard treatment. The follow-up on these patients at the time of this report varies from three weeks to six and a half months.

Toxic Effects — The immediate effects of the drug occurred within one to six hours after in-These effects consisted of nausea, vomiting, and anorexia in 11 patients symptoms were less marked after the first day, and frequently, subsequent injections caused only Anorexia alone was observed in 2 patients, diarrhea in 2 patients, and no reaction in 2 others One patient noted headache follow-It is of interest to remark that ing injections those showing no reaction were probably the 2 None of these most severely ill in the series toxic symptoms persisted after the course of injections was completed Thrombophlebitis at the site of injection developed in only 1 case

Perhaps the most serious toxic effect of the drug was the hematologic change produced Except in patients who received blood transfusions, the hemoglobin and erythrocyte determinations showed a transient decrease. This was most marked within the first three weeks except in cases of polycythemia vera where the maximum



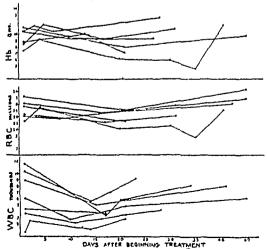
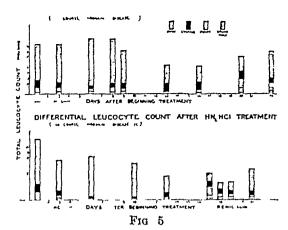


Fig 4



drop usually occurred after the first month and persisted longer than in the other diseases Leukocyte counts showed a significant decrease in all but 1 case This phenomenon manifested itself in an initial lymphopenia, followed by a neutropenia within two to six days Recovery of the blood picture was noted as beginning in the third or fourth week, and in patients who showed a good response to therapy, recovery was usually complete in eight weeks Some typical changes, showing the composite of the blood pictures in 6 cases of Hodgkin's disease, are presented in Figure 4 One patient received 2 courses of treatment and his leukocyte counts are included in this chart Figures 5 and 6 show

DIFFERENTIAL LEUCOCYTE COUNT AFTER HN HCI TREATMENT (POLYCYTHEM A VERA PT)



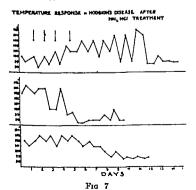
the changes in differential count following therapy in 1 case each of Hodgkin's disease and polycythemia vera In Figure 5 the changes occurring in both the first and second courses are shown On the eighteenth day after the second course, the patient developed stomatitis, and penicillin was administered until the twentyfirst day with subsequent clearing of the lesions The polycythemia vera shows the most severe drop in leukocytes recorded in this series, going from 20,000 on admission to 500 white blood cells on the fifteenth day after therapy had begun In spite of this, no untoward complications en-It is of interest to note also that therapy was undertaken on 1 patient with an initial blood count of 650 with excellent clinical response and an actual improvement in the leukocyte picture

The leukopenia in 2 patients of this series was complicated by mouth lesions resembling Vincent's angina, treatment with penicillin and oridizing mouth washes was required Excellent reponse was obtained in both these patients under such therapy. One other patient received penicillin prophylactically when his leukocytes dropped to 2.000

In all patients followed with platelet counts, a significant decrease was noted, paralleling the hemoglobin change. Other investigators mention purpura as a complication of this drug induced thrombocytopenia, but such has not been noted in our series. 3.4

Hodgkin's Disease.-Six patients Results. with Hodgkin's disease have been treated with responses in all after the initial course. Remisgions have been induced lasting from one to five months. Three of these had had previous x ray therapy, and one had been classed as unsuitable for further therapy by that method sponse in these cases has been marked by reduction in the are of lymph nodes, spleen, and liver and a remarkable return of temperature to normal. Typical cases are shown in Figure 7 Weight gams of 5 to 20 pounds (2 4 to 9 Kg) and remarkable improvements in appetite have been noted One patient, whose clinical picture was that of Hodgkin's disease but in whom a positive biopsy was not obtained, was relieved of persistent abdominal pain, following a course of nitrogen mustard

Two cases have had recurrence of symptoms and response to re-treatment. A third patient illustrates the limitations of this drug This was a 42-year-old man with a fifteen year history of lymphadenopathy, proved mne years before admission to be Hodgkin's disease by lnopsy X-ray therapy had given good remissions until



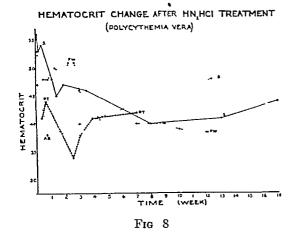
September, 1946 At that time he noted weight loss, weakness fever, and anorexia. The x ray department of this hospital felt that he would not respond to further therapy On November 4, 1946, he was given his first course of nitrogen mustard injections and was transfused twice His symptoms subsided, and a 20-pound weight gain was recorded In January, 1947, a recurrence of symptoms followed, and after a tenweek remission he was re-treated. A seven week interval of relief took place, and exacerba tion at this time prompted a trial of x ray therapy Little or no improvement was obtained and in April, 1947, a third course of nitrogen mustard treatment was given. This did not produce a response, and he expired ax weeks

It is suggested by our findings in this case, and substantiated by the published case reports that nitrogan mustard will induce a response in Hodgkin's disease patients who are x ray refractory or in whom such thorapy is deemed inadvisable. At the same time, however, it may be inferred that response to nitrogen mustard will gradually become less and less on repeated treatment in the same patient.

Polycythemia Vera — Four patients with polycythemia vers were treated with responses of three to five months' duration. One of these patients was diagnosed as a possible example of the transition from polycythemia to early myelogenous leukemia because of the appearance of a 20.000 leukocyte count and myeloblasts seen on blood smears. The hematocrit changes in these patients are shown in Figure 8. All of these patients were relieved of symptoms, such as headache, vertigo, and paresthemas of the extremities One patient with pain over the spleen which extended to a point just above the nubis obtained marked relief from pain, and the size of the spleen was reduced to an area within 6 cm. of the costal margin. Reduction of splenomegaly was a constant finding in these cases.

The degree of improvement in the climeal condition of patients with polycythemia treated here is in accord with that obtained in the 5 cases thus far reported in the literature 4 Al though the response in these patients is slightly slower than in the other diseases in our series, it appears that the duration of the romissions may be longer, some reported to have lasted up to fifteen months.

Lymphosarcoma.—Three patients with lymphosarcoma have been treated with nitrogon mustard with a follow up of three weeks, three and a half months, and six and a half months, respectively These cases have shown remarkable reduction in lymphadenopathy and in 2 cases weight gain has been recorded. The first pa-



tient in the Albany Hospital series is included in this group, having entered with a three-month history of painful swelling in the right axilla. This had become worse until, on admission, there was edema and swelling of the entire right arm, and the patient was unable to move the extremity without pain. The nodes were noticeably smaller within six days, within six weeks all adenopathy and edema had disappeared, and the patient felt able to return to work. This remission still continued six and a half months later with a total weight gain of 18 pounds

It appears from our cases and those reported that the response of lymphosarcoma to methylbus (\$\beta\$-chloroethyl) amine is very similar to that produced by roentgen therapy. A true companson cannot be made as yet, but it is to be remembered that in the localized form of this and similar tumors, radiation therapy can be concentrated on the involved areas

Leukemia —We have undertaken treatment on 2 cases of leukemia in our series, both of them being chronic myelogenous leukemia in elderly women in the advanced stages of their disease One patient had had previous x-ray therapy and had received over two hundred transfusions at weekly intervals Therapy was undertaken on this patient as a last resort No apparent effect was obtained, and she died twenty-five days after the course was begun Autopsy showed no changes in the leukemic state attributable to the nitrogen mustard therapy The course of the second patient was steadily downhill and was remarkable only in the transient improvement in the white blood cell series shown in the fourth week when the myelocytes dropped to 3 per cent from a previous 20 per Autopsy was not obtained on this patient

Our brief and discouraging experience with leukemia has conformed to that of the previously mentioned authors, and it is doubtful whether nitrogen mustard has any advantage over other known methods of therapy for this disease These 2 patients were treated early in our series, and we have been hesitant to treat further cases

Summary and Conclusions

The chemical and biologic actions of the mustard compounds have been reviewed. Following the reports of other investigators, working with the nitrogen mustards in patients with neoplastic disease, 15 patients have received 19 courses of treatment in the Albany Hospital since November, 1946. The results of this series of cases have been reported and our clinical experience reviewed.

On the basis of the physical, symptomatic, and hematologic changes observed in these patients, we feel that the use of the nitrogen mustards in Hodgkin's disease, polycythemia vera, and lymphosarcoma will frequently induce temporary remissions. Our experience, confirming that of other workers, does not allow a similar view of the leukemias treated with this substance, namely, methyl-bis(\$\beta\$-chloroethyl)amine Further follow-up on this work must be done before final conclusions can be reached

The toric effects of the drugs make them potentially dangerous, and it should be emphasized that they must be used with care, both in handling and in the follow-up of their effects on the hematologic picture

The greatest value of the nitrogen mustard compounds lies in the potentialities which they possess by virtue of their chemical structure. We view with optimism the possibility of obtaining less toxic and more effective compounds in the future as a result of changes in chemical formula. At least one chemical approach to the problem of neoplastic disease appears to have been opened as a result of the investigation which has been carried out and is now being continued.

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ON ORIGINAL WORK IN PLASTIC SURGERY IN NEW YORK STATE

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THERE can be few intelligent laymen, mediwho have not some preconceived opinion of what
constitutes plastic surgery Before the recent
war, well bruited were the wares of those who
lifted the wixened face, electrocuted the undesired hair. During the war, while articles written
for laymen told faneiful tales of the restoration to
normal of destroyed faces reconstructive surgery,
always an important element of military medicine, made real headway in the hands of reconstructive surgeons, Major Arthur E Sherman,
of East Orange, Commander Samuel M. Dupertus, of Pittsburgh, and Major Gerard Devoe, of
New York City, to mention a few

If by plastic surgery you mean reconstructive surgery, you imply that general surgeons restrict themselves to extirpation, unless you are willing to admit that most surgeons practice plastic sur gery and that many plastic surgeons limit their work to certain regions. The latter is nearer the truth. Pelvic reconstructions remain the prov ince of the general and gynecologic surgeons The orthopedic surgeon constructs as well as amputates Today, as through the centuries the ophthalmic surgeon exercises ingenuity and maintains interest in the essentially plastic surgery of the extraocular muscles correcting a num ber of varieties of strabismus Besides in shortening and lengthening these muscles, he has developed technics for their transplantation has devised major procedures for the reconstruc tion of the eyelids, structures which have two important surfaces and which are not immobile The movement of the upper eyelid can be well compared, as it opens and recesses itself into the orbit, to the roller top of a deak. The technics of ophthalmic surgeons, in the correction of ptosis utilizing by transplantation the superior rectus and levator muscles which pull into the orbit produce an effect more naturally functional than the method commonly employed by general plastic surgeons, who link the lid, as though it were a curtain, to the muscle structure of the forehead. It is not necessary to labor the point when it comes to the problem of corneal transplantation, of who is best qualified to undertake this variety of plastic surgery

In this general connection it is notable that before our era of rather intense specialization surgeons who were interested particularly in the operative cure of cataract and of strabismus were usually prime movers in orbital and general tissue reconstruction. Moreover, those who call themselves plastic surgeons undertake cases where, as in advanced malignant tumors of the head, the surgery is entirely extirpative, since much reconstruction is not practicable.

Does the history of plastic surgery in this country confirm the European inference that reconstructive surgery is naturally the contribution of regional surgeons interested in restorative problems? A century ago Warren in Boston Mutter in Philadelphia, Post in New York City and Frank Hastings Hamilton in Buffalo were the leading exponents of plastic surgery on this side of the Atlantic. Most of these doctors were particularly interested in surgery of the eye and surrounding structures, two of them Post and Hamilton, each published in the 1840's treatises on the surgical correction of strabismus Of them, Hamilton exerted perhaps the most extended influence, certainly he contributed more in the way of original technics

The settlement of western New York State by the white race dates only from 1788 In 1814, Buffalo was burned In 1830, the population of Buffalo was less than 9,000 that of Rochester less than 10 000, that of Syracuse about 2,000, and the population of Albany was nearly 25,000

In western New York State, I find no record of plastic surgery prior to Frank Hamilton and substantially no record of any plastic surgery being performed by anyone else prior to the Civil War (In 1855, Dr H A. Potter of Geneva, New York, removed an upper jaw that is, the maxilla and surrounding tissue because of the presence of a tumor, apparently a carcinoma originating in the antrum) On the basis of published case reports, Dr Hamilton was undertaking more reconstructive surgery than anyone else in the state and about as much as any sur geon in the country During this period surgical interest in plastic technics mounted sharply is clear that there was then a new realization of the various great possibilities of surgical reconstruction

Dieffenbach who published his maugnural dissertation on this topic in 1822 his classic monograph in 1829 and his Operative Surgery dealing with reconstruction technics in 1845, was widely read Velpeau's Operative Surgery translated by an American P S Townsend, under the supervision of Valentine Mott, presented a large amount of material much of it of recent origin.

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, Section on History of Medicina, May 8, 1947

in this field. The translator published the large section dealing with plastic surgery in the first volume because "it will be generally considered of higher interest. Than any other part of the work it contains nearly all the latest discoveries and processes in that most important branch of the art which has not inaptly been called *New Surgery*, since it has sprung up, or rather, made such astounding advances within the last ten years only, that it may be almost said

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So keen was the interest in this subject, that an American Appendix of 175 pages was appended to this volume, dealing with new technics in plastic reconstructions developed in this country during the decade.

to date its very birth and existence within that

short period of time"

It is, by the way, quite clear that the great expansion in applying the principles of plastic surgery during the middle third of the nineteenth century was not due to the discovery of surgical anesthesia mainly. Dr. Hamilton was ultraconservative in his views regarding the safety and general use of anesthesia, and most of his operations during this time, when he made a number of original technical contributions to the field of plastic surgery, were done without anesthesia of any sort.

The career of Dr Hamilton fully annotates the early history of plastic surgery in western New York. Dr Frank Hastings Hamilton, one of the founders of the New York Medical Association, was born September 10, 1813, and died August 11, His father was a farmer and owner of a line of stages which ran between Bennington and Brattleboro, Vermont, across the mountains 1816, his parents moved to Schenectady, where he studied at the Lancasterian School and later at the Schenectady Academy He entered Union College and was admitted to the sophomore class in 1827, when he was only fourteen years old then entered his name as a student of medicine in the office of Dr John George Morgan, at that time physician to the State Prison at Auburn, and, therefore, permitted to use the bodies of dead convicts for dissection. During the winter of 1831-1832, Hamilton attended a course of lectures at the College of Physicans and Surgeons of the western district of the State of New York at Fairfield, Herkimer County The class numbered 201, of whom four graduated, for at that time comparatively few graduated from medical Most of the prospective surgeons were examined by county censors, a few by state censors, thus attaining a license to practice In 1833, Dr Hamilton received a license to practice medicine and surgery from the Cayuga County Medical Society and opened an office in Auburn Dr Hamilton took the degree in medicine at the University of Pennsylvania He returned to Auburn and commenced teaching by delivering a private course upon anatomy and surgery

Four years later, Dr Morgan, his preceptor, relinquished his teaching in Auburn for the professorship of surgery at the Geneva Medical Dr Hamilton was appointed in his place at the Western College of Physicians and Surgeons of Western New York. The announcement was made in the annual bulletin of the college as follows "Since the close of the last session, the vacancy in the professorship of surgery has been filled by the appointment of Frank Hastings Hamilton, M D, of Auburn, a gentleman every way qualified to discharge the duties of Dr Hamilton over a period of years has been distinguished as an able and eloquent teacher of anatomy and surgery He comes to the institution with the highest testimonials in his favor as a lecturer, and the trustees are happy to say that his appointment has been made in accordance with the unanimous wish of the other members of the faculty The trustees, therefore, feel confident that the duties of the important chair of surgery will continue to be ably discharged and the same unity and harmony, for which the faculty of the institution has so long been distinguished, will remain unimpaired"

At the time of the first appointment to a professorship of surgery, Dr Hamilton was twenty-six The Boston Medical and Surgical Journal, referring to his appointment at that time, said in part, "He is a persevering, industrious student and, therefore, will succeed anywhere. Men of his power and activity, to say nothing of genius, are very much needed in more than half the medical schools in the union Everything goes by management in these degenerate times. To one person fitted by nature for the station of a lecturer on science—in too many scientific institutions—there are ten stupid-headed drags, who neither elevate themselves nor advance the cause of useful knowledge. It is strange that those who have the care and keeping of the honor of medical seminaries do not open their eyes to the monstrous and glaring iniquity of putting cousins, nephews, and almost aunts into chairs which it is not possible for them to sustain with dignity or profit to the world, yet all this is done, to the disgrace of the age while those most competent are left to grope through life in obscurity tion of Dr Hamilton is one of those deviations from the common policy of our medical schools which actually excites our encouragement"

In the following year, Dr Hamilton was made professor of surgery in Geneva Medical College Later in the same year he moved to Rochester, New York, where he practiced until March, 1844 He traveled for seven months in Europe The following year he moved to Buffalo, where he abortly met Dr Austin Flint, Sr, and a lifelong friendship developed

He was immediately appointed surgeon to the Buffalo Hospital of the Sisters of Charity position he held until he moved to Brooklyn in 1859, and his published case reports from his teaching clinic at this hospital, in the Buffalo Medical Journal contain many references to developments original with him in the field of plastic surgery In 1846, Dr Flint and Dr Hamilton, together with Dr James P White founded the medical department of the Univernity of Buffalo Dr Hamilton became its professor of surgery From 1846 to 1858, he retained this position at the University Hardly had he been settled in a new home in Brooklyn, in 1859 than he was appointed the first professor of sur gery at the Long Island College Hospital the outbreak of the Civil War he entered the army as a volunteer regimental surgeon Rather rapidly his responsibility was increased by successive appointments, culminating in that of medical inspector of the United States Army with the then high rank, for a medical man, of licutenantcolonel During the war he became professor of military surgery in the Bellevue Hospital Medical College, where in 1868, he was made professor of the principles and practice of surgery and surgical pathology

It may be said that Dr Hamilton was a master of the extirpative and reconstructive surgery of his day He was particularly interested in the extraction of cataracts, while he was in Buffalo and then, as well as later, in the technics of amputations, in which his work, including the exact choice of site, became authoritative. His interest in tissuo restoration was broader than merely surgical he theorised extensively on the mechanism of the formation of provisional callus he published on the art of obtaining primary union in incised wounds His publications in the field of restorative surgery include a curious account of the regrowth of an entire phalanx after its surgical extraction, an extensive early work on the surgical correction of strabismus, an original technic for blepharoplasty, reports of the correction of ectropion of both upper and lower eyelids by implantation of the pedicle flap, and reports of the surgical creation of new noses, new cheeks, the correction of hare-lip and cleft palate, the correction of tonguetie and of ptosis of the upper eyelid

I find that it was Hamilton who evolved the principle of attaching skin to periosteum in order to secure permanent placement of skin where there is a tendency toward retraction. I need not tell you that this principle is of great practical importance and accounts for the success of the

late Dr John Wheeler's procedure for the reestablishment of conjunctival formers Dr Hamilton is to be credited with also the first suggestion for grafting skin from distant sites to cover the surface of chronic ulcers, and there is some merit in his claim for priority in the actual carrying out of this suggestion, although his claim was disputed by a Dr Watson in an amusing, minor chapter in the annals of medical controversy

During the decade preceding the present one by a century, Dr. Hamilton operated upon all the varieties of cases mentioned above and as well for varus, in which he cut the tendo achilles entaract, glaucoma, pterygium, essentially a plastic procedure, naevus and other tumors of the skin, hare-lip, sarcoma of the choroid with exten sion into the orbit, and malignant tumors of the lins.

Upon one patient afflicted with multiple deformities of the face, he performed blepharoplasty cheloplasty and rhinoplasty First, he corrected the ectropion of the upper hd, mainly by freeing the conjunctiva and tarsal plate, and by excising a portion of what appeared to him to be redundant tarsus. Today, we would condemn this procedure on the ground that it is not reasonable to excise tasue to correct a lesion consisting essentially of inadequacy of tissue amount.

Next, he made a similar attempt upon the lower lid. He immediately recognized his failure, which he ascribed, perhaps narvely, to 'complete inelasticity of the integument below (the lid margin?). He did better when he used a pedicle flap from the temple.

The deformity about the angle of the mouth he corrected by what appears, in a rather vague description to have consisted of undermining and sliding of skin and mucosa

'These operations having been completed, the patient went home to re-establish his health which had suffered some from his confinement and the constant irritations of successive operations'

After the patient's convalescence, Dr Hamil ton restored the right side of the nose by a sliding Then, because he was unwilling to further deform the face by securing tissue from it and although he had previously performed rhinoplasty only by the Indian method of forehead flaps, he now resorted to an original variant of the Venetian method He transposed skin from the hand, having as he wrote "previously tested the courage and endurance of the patient " His brief description of the operation breathes a simplicity nostalgic for a day when life was less complex "On March 29 I dissected from the ball of the thumb of the right hand a piece of integument of a quadrilateral form two inches in length by one and a half in breadth, its longest diameter extend ing from within outwards and its base or point of attachment resting over the radial border of the metacarpal bone of the index finger The palmar portion of this flap was at this time covered with a heavy cuticle The wound was closed as nearly as possible with adhesive plasters, the flap was turned back, dressed with simple cerate, enveloped in cotton, the whole being secured by a few light turns of the roller In six days, about onefourth of the flap had sloughed, the sloughing being arrested by yeast poultices At the end of two weeks, the flap, by sloughing and contraction, had diminished to about half its original size was, however, three times its original thickness and vascular, the thick cuticle had fallen off and left a soft, pliant skin, and edges were cicatrized"

On April 12, a cap with straps, was placed on the patient's head, the flap and the nose were made raw, and by means of a sling to which the straps from the cap were attached, his arm and hand were brought up, and the skin secured to the nose by five small sutures. A pillow was slung under the armpit, against which the elbow rested. Two students now remained in constant attendance, being relieved every four to six hours by others. The patient was kept in this position seventy-two hours, when, union having taken place, the flap was separated from the hand. Of that which remained attached to the face, a small portion sloughed, but sufficient remained to partially complete the ala

Finally, the left ala not complete, Dr Hamilton performed an operation for which he claimed entire originality This operation was possible because a burn had destroyed the roots of most of the hairs within the nostril and also had left the mucous membrane and the subjacent tissue much thickened He raised, by careful dissection, a thick plate covered with mucous membrane from within the nostril, leaving a pedicle downward and at the part of the opening of the nostril which is nearest the external commissure of the mouth. this plate he brought out and attached to the apex of the nose and to the lower border of the attenuated ala The success of this particular procedure "exceeded his expectations"

In the operation for hare-lip prior to Hamilton's time, controversy centered on when to operate and on the choice of instruments. The hoary battle of the kmfe (scalpel to you, Dr. Kildare) and the scissors was raging even then. It was Richter who finally had said, "Every surgeon may and can select the instrument he thinks the most convenient, both have been used with equally good results"

There had existed a prejudice against operating on children with hare-lip before they were two years old Heister had opposed this prejudice, his comments in this regard provide a circumstantial commentary on the surgical milieu of the century preceding Hamilton

"It has been an opinion of the ancients that it is not safe to perform the operation for a hare-lip upon infants before they are two years old, or even till they are four or five, according to Garengeot The contrary of which is taught by experience, from whence we are furnished with instances of infants happily cured of a hare-lip. when they have not been above five or six or even three months old, if they are well in other respects and the operation rightly performed parents are seldom willing to defer the operation so long, and I have seen them so uneasy on this account that they would rather employ an itinerant quack in the operation than postpone it for any time, nor indeed have these mountebanks It is disagreeable to parents often miscarried in general that their children should appear with such a blemish, and it is often of bad consequence to the mother in succeeding pregnancies to have such objects in their presence, by which means the deformity is propagated in the family therefore, I would advise expert surgeons not to be afraid of performing this operation too early, especially when the fissure is but small also a necessary circumstance in infants, to keep them from sleeping a considerable time before the operation, and afterwards to give them an anodyne that they may sleep the better and he still the longer after the operation without moving the lips by crying It should also be observed rather to let the infant lie with its face downward during the operation that the blood may not run down its throat, and set it a coughing though the hemorrhage is often pretty plentiful in performing this operation in young infants, yet no danger can be well expected from thence, for it rather prevents inflamation, and generally ceases after applying the bandage and dressing to the lip"

Although Dr Mutter in Philadelphia and Dr Mason Warren in Boston then held that the operation upon hare-lip should be carried out as early in life as possible, Dr Hamilton believed that the very young infant was more predisposed to postoperative infection and preferred the period during the second year immediately following or preceding dentition. If it was not done during the first few years of life, he found it necessary to wait until there was enough adult understanding to permit the operation to be performed without anesthesia.

In 1858, Hamilton extirpated the entire parotidgland That the parotid had previously been removed had been disputed hitherto, and that it was removed, in this case, for the first time, was confirmed by microscopic examination of the tissue by Dr Austin Flint, Jr It was in this year

that Dr. Hamilton defended with his pen the claim previously advanced by Oliver Wendell Holmes regarding the contagiousness of puerperal The recent teaching of Dr Meigs on child-bed fever and the lecture of Professor Hodge of Philadelphia had reopened the discussion, which Dr Holmes had met by the re publication of his essay

In view of the fact that this material has been prepared for the Historical Session of the Annual Meeting it is, perhaps properly, somewhat discursive Much of it treats of details of the medical career of Dr Frank Hastings Hamilton, who practiced in western New York State the facts presented it is clear that reconstructive surgery was developed in the main by regional surgeons rather than by men who limited their interest to plastic surgery, and that there are sufficient reasons to warrant the conclusion that a good deal of plastic surgery will stay in the hands of surgeons limiting their interest to par ticular regions. It is certain that there are com petent general, as well as regional, plastic surgeons. it is almost equally certain that the work will remain in the hands of those competent

454 Franklin Street

RECORDING MEMBERSHIP AND FELLOWSHIP IN THE NEW DIRECTORY

The information cards received from physicians who have listed their data for the new eighteenth edition of the American Medical Directory, indicate increasingly that many are not aware of the differ ence between Membership' and 'Fellowship' in the American Medical Association.

Here are the official definitions

Every Member in good standing in the con-stituent medical association of the state in which he is engaged in practice whose name is officially reported to the Secretary of the American Medical Association for enrollment becomes automatically a Member of the American Medical Association and is not called on, as such, to pay any dues or to contribute financially to the Association. Members of the American Medical Association

are eligible to apply for Fellowship
To qualify as a FELLOW, a MEMBER in good standing is required to make formal application for Fellowship to pay Fellowship dues and to subscribe for the Journal. Applications must be approved by the Judicial Council. Fellowship dues and subscription to the Journal are both included in the one annual payment of \$12 which is the cost of the Journal to subscribers who are not Fellowa

Members of constituent state medical associa tions pay dues to those bodies, but as Members they pay nothing to the American Medical Association. Fellows pay dues and subscription to the Journal in the sum of \$12 a year which has nothing to do with county or state dues.

According to an amendment to the Bylaws of the American Medical Association, no physician may be officially recorded as a Member of the American Medical Association except on the basis of membership in one constituent state medical association and that one the association of the state in which the physician concerned maintains legal residence and engages in the practice of medicine.

Each Fellow receives a Fellowship Card from the Association annually as payment of his dues is recorded, which card is presented for admission to the Annual Meetings of the Association

Physicians who are eligible for Fellowship should make formal application immediately so that they may attend the Chicago Session and so that a record of their Fellowship may be received in time to include the Fellowship symbol in their data listed in the new American Medical Directory - J A.M A., February 7 1948

MOST DEATHS IN 1947 CAUSED BY HEART AILMENTS AND CANCER

Heart allments and cancer caused 72 per cent of the deaths among Americans last year, according to a recent study of 1,000 000 policy holders of the Mutual Life Insurance Company of New York.

Diseases of the heart and circulatory system were responsible for 57 per cent of the deaths in all age groups and 62 per cent in persons 60 years old and over the study showed. Mortality from cancer was 15 per cent in all age groups. Other causes of death, in order were accidents

kidney disease, influenza and pneumonia, suicide and tuberculosis.

NERVE BLOCK THERAPY FOR PAIN OF LARYNGEAL TUBERCULOSIS

E M PAPPER, MD, and E A ROVENSTINE, MD, New York City

(From the Department of Anesthesia, Bellevue Hospital)

Larryngeal tuberculosis, although comparatively infrequent in clinical practice, may present a most difficult problem in therapy to the phthisiologist, particularly when the disease is far advanced. It is the purpose of this communication to outline the value of superior larryngeal nerve block in the management of some of the distressing symptoms of this lesion. No attempt will be made to discuss the phases of care which are properly the concern of the larryngologist and the internist

Special attention is directed to the patients whose existences are miserable because of severe dysphagia and exquisite pain associated with swallowing or phonation. Occasionally this may be complicated by pain referred to the ear Although many authorities state the prognosis is not necessarily poor, the patients observed here were, for the most part, critically ill, and nerve block was performed as a palliative procedure for the relief of symptoms.

The therapeutic rationale for superior laryngeal nerve block is based upon the innervation of the larynx, its normal physiologic activity, and the changes effected by the lesions of tuberculosis

The superior laryngeal nerves are bilateral They are branches of the vaga and the chief sensory nerves of the larynx, although motor components are present The mucosa of the larynx and epiglottis are supplied by these nerves and transmit afferent impulses which are interpreted as irritation or pain in disease of the Among the many functions of the larvnx larynx are those of assistance in deglutition, phonation, cough, and expectoration It can be seen, therefore, that a lesion of the larynx, such as tuberculosis, may cause considerable pain almost constantly because of the frequency with which the larynx is called upon to perform one or more of the functions listed, and that the pain may be avoided by neurolysis of the superior laryngeal nerves It is apparent also that this procedure is directed toward symptomatic relief and does not necessarily alter the course of the disease

The superior laryngeal nerve is accessible tonerve block above the point of its passage into the larynx through the thyrohyoid membrane, between the great cornu of the hyoid bone and the superior cornu of the thyroid cartilage (Fig 1)

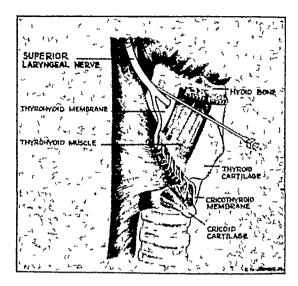


Fig 1 Diagrammatic drawing to illustrate the position and course of the superior laryngeal nerve at the site of nerve block with needle in place

In performing nerve block the patient is placed in the supine position and a skin wheal is raised in the midline just above the thyroid notch (Fig 2) A 5-cm needle is then introduced through the wheal and advanced toward the cornu of the hyoid bone—Injection is completed just below the hyoid cornu with 2 cc of 2 per cent procaine,

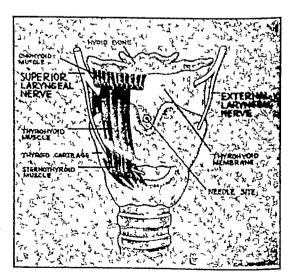


Fig 2 The drawing indicates the location of the skin wheal in relation to the thyroid cartilage

followed by 2 cc of absolute alcohol at least ten minutes later The opposite side is anesthetized in similar fashion through the same skin wheal Successful completion of the procedure results in immediate pain relief which persists for variable periods of time, ranging from weeks to months.

Bilateral superior larvngeal block has been per formed recently upon 15 patients with laryngeal tuberculosis at Bellevue Hospital, for the relief of severe, intractable pain during cough, deglutition, or phonation. All patients had ex tensive pulmonary tuberculosis, which was con sidered hopeless for cure, and all died within twelve months of the onset of serious laryngeal involvement. Eleven of these patients were less than 40 years of age, with the majority in the fourth decade of life. The larvngeal lesions in all instances were far advanced patients were subjected to nerve block once and 2 patients were injected on two separate occaaiona

Excellent pain relief was obtained for 10 pa tients, all of whom remained comfortable for at least six weeks. Three patients had only a fair result in that symptoms were gradiented incompletely for the same period of time, and complete failure occurred in the treatment of the remaining 2 patients. The 2 patients subjected to a second nerve block gained relief from both procedures.

In no instance was the lesion improved but the procedure was definitely of value for most of the patients in the comfort they experienced with freedom from the agonizing pains of the disease It is suggested that superior laryngeal nerve block with procaine and absolute alcohol is a merciful addition to the management of patients with painful larvneeal tuberculosis

Summary

The mechanism of pain in laryngeal tuberculosis is discussed, and superior laryngeal nerve block is recommended for therapy

ANNOUNCEMENT

From the Council Committee on Public Health and Education of the Medical Society of the State of New York

Statement Regarding Proposed Pediatric Consultation Services

The Medical Society of the State of New York and the New York State Department of Health agree on the principle that adequate pediatric consultation services should be available to general practitioners. Such pediatric consultation services are primarily a technic of graduate education which will in the long run improve the quality of medical care to all the children of the State. As such it is of concern to the

two organizations issuing this statement.

Private practitioners should be encouraged to make greater use of pediatric consultation services. For patients who cannot obtain the needed consulta tion services, including indicated laboratory and x-ray examinations, such services ahould be made available to general practitioners through the instru mentality of the public health program on a regional basis radiating from a pediatric center Inasmuch as technics for providing such services have not been developed in detail, it is proposed that a pediatric consultation program be instituted in a single region of the State on an experimental basis. The Buffalo region has been chosen for this demonstration.

In the development of pediatric consultation services, major emphasis should be placed upon consulta nons for groups of patients in such locations that the needed laboratory and x-ray examinations may be readily provided The referring physician is rereadily provided The referring physician is re-quired and other physicians are encouraged to at-tend the group consultation. In connection with such group consultations teaching conferences and other educational devices should be arranged for the ounce consulant. In view of the varying dreum-stances in each case the referring physician must be the individual to determine if pediatric consultation service including indicated laboratory and x ray examinations, is otherwise available to his patient.

Individual consultations by pediatricians have been provided to a limited extent as part of the publie health program for many years No change in policy in this regard is proposed.

INTRACTABLE EDEMA

Clinical Therapeutic Implications

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THIS discussion will evalude from consideration intractable edema due to local peripheral causes, such as recurrent thrombophlebitis with venous and lymphatic obstruction, inflammatory or neoplastic occlusion of lymph channels, arthropathic, paralytic, or other types of immobilization of lower extremities. We turn, therefore, to the more general types of edema, associated with congestive heart failure, renal disease in its various stages, malnutrition, constrictive pericarditis, cirrhosis of the liver, diabetic glomerulosclerosis, undiagnosed myvedema, hypothyroidism, steroid hormone imbalance, and the rare scleredema

The physiologic mechanisms underlying the development of edema have already been ably discussed by Dr Peters, but at the risk of repetition I should like to re-emphasize the major factors favoring edema under clinical conditions 1 These conditions may be grouped for convenience under renal dysfunction, venous and capillary hypertension, low plasma albumin concentration, sodium intake, capillary damage, lymphatic obstruction or stasis, and excess of salt and waterretaining steroid hormones and possibly pitressin, regardless of their chief site of action factors in edema may be variously combined in clinical situations In fact, there is almost never any single factor operating alone in human Frequently, this has been forgotten by those who have championed some one cause of a certain clinical edema or have as vigorously attacked another investigator's point of view What we must never forget is that the sodium intake is the sine qua non for all types of chronic edema, with one exception, to which I shall allude later

One factor favoring edema that has not yet been mentioned is time. This factor is important, because it takes time for edema to become apparent, clinically, even though several of the other major factors may be active. This is the answer to the catch question, "Why does not every patient with shock and a very low renal blood flow and glomerular filtration show edema, if you blame cardiac edema on diminished filtration of sodium?" If you could keep the patient in shock for a few days and

Based on a paper read as part of a symposium on the treatment of intractable edema before the Brooklyn Society of Internal Medicine May 28 1947

feed him hot salted soup instead of hot coffee, I suspect he would develop edema like the cardiac subject Postoperative edemas are a good example of a combination of diminished renal filtration, an excessive intake of sodium (parenterally), and the revealing effect of time

An understanding of the basic physiologic disturbances in the various types of clinical edema leads logically and actually to more Thus, the early use of successful therapy BAL(2,3-dimercaptopropanol) in arsenic or gold dermatitis with edema due to capillary injury results in rapid subsidence of the process. The proper renutrition of an emaciated, edematous, concentration camp inmate gives a gratifying The timely reduction in dosage of result desoxycorticosterone acetate in an overtreated edematous case of Addison's disease may be These are, of course, relatively easy examples, and do not really belong under the heading of intractable edemas

Cardiac Edema

The mechanism of cardiac edema may be outlined as follows

- (a) "Forward failure" sequence
 - 1 Myocardial insufficiency
 - 2 Decreased cardiac output—relative or absolute
 - 3 Decreased blood flow
 - 4 Renal vasoconstriction, chiefly efferent, release of renin
 - 5 Low glomerular filtration
 - 6 Low clearance of sodium
 - 7 Edema and hypervolemia
 - 8 Venous hypertension
 - b) "Backward failure" sequence
 - Myocardial insufficiency
 - 2 Venous hypertension
 - 3 Edema and hypervolemia
 - Passive congestion of organs
- (c) Exercise—aggravates edema formation from both (a) and (b)

Concerning cardiac edema, we have two clinical goals first, improvement of circulation by the usual regime, and second, dietary control of salt (sodium in any form) within the limits of renal excretory capacity on the one hand and the patient's nutrition on the other. If the first succeeds, the second is no problem or at most a minor one, but chronic congestive failure implies

that improvement of the circulation has fallen short of the mark. Hence, one must concentrate on dietary restriction of sodium or accept the alternative of frequent use of mercurials with all the unpleasantness of violent swings in body fluid, electrolytes, tissue turgor, etc., not to mention other reactions. It is almost like waiting for ketosis each time, before instituting a diabetic regime and insulin, while leaving the latter off in the intervals.

When a patient requires a mercurial once a week or oftener, he is uncomfortable, physically, 50 per cent or more of the time, and almost normal life including some work capacity, is virtually excluded. If he fails to respond to 1 or 2 cc, he soon receives 3 4, 6, or 8 cc in some quarters, all this not infrequently, without any serious effort to control salt in the diet. Even in this great medical city, where patients can shop from one cardiac clinic or hospital to another, it is remarkable how many escape any significant instruction in low salt diets simple example, few hospitals bake salt-free bread and it is quite a shopping feat to find saltfree bread outside of hospitals For this reason, at the Montefiore Hospital we have arranged for decompensated cardiac patients to buy salt-free bread at our pharmacy

Our medical fathers and grandfathers would be amused at the contemporary furor over the rediscovery of the effectiveness of the low salt diet in cardiac edema They knew all about it in the years between 1900 and 1920, when the organic mercurial diuretics were not known Long before 1900, the Karrell diet with its 4 or 5 glasses of milk a day and a sait content of only 1 gm , was a very potent antiedema regime, even though woefully deficient in calones, iron, protein, vitamins, and palatability Its use for short periods is still a very practical and highly effective discipline for a chronically water logged individual, but it carries the disadvantage of conveying to the patient the idea that milk is good for him. He cannot understand then why it is eliminated from his later fuller cardiac diet. However, as the palatability of sodium-free milk is improved this restriction may soon be lifted, permitting the more liberal use of the well known nutritional qualities of milk and its prod ucts in the cardine diet

With sait-free bread, sait-free milk, unsaited butter, and a little plain cottage cheese, the chief hazards of the low sait duet are by passed, provided natural unsaited foods are used as meats fruits, and vegetables with only a few exceptions such as bacon ham, beets kale celery, spinach, and sait water fish. Beware of corn flakes, dry cereal, and oleomargarine, and, of course, canned vegetables or their juices. One can easily arrange in palatable and varied diet containing

only 1.5 gm of salt. In case of severe rebellion on the part of an undernourished or anorexe patient, the additional use of 1 Gm. of salt daily from a salt shaker at the table is permitted. The total salt intake of 2.5 Gm would still be less than half of the ordinary so-called salt poor diet used in many institutions. After the first few morcurials, the interval between injections may be increased to two or more weeks, and in many instances, the patient may be restored to sufficient activity to permit occupational rehabilitation. The change in morale of the patient with chronic heart failure is the most gratifying result. For those whose cardiac reserve is too low to permit physical activity the reduction of clinic visits or medical fees and the decrease in the number of emergencies due to acute pulmonary or hepatic congestion is an adequate reward for adherence to a low salt diet.

Obviously, the less severe the degree of congestive failure the more readily will a good response occur. Our chronic cardiac patient at Montefiore Hospital is a tough therapeutic problem but the diet works on him. We insist that every patient have a scale at home so that he can weigh himself daily and keep a record. The patient soon learns what happens if the diet is broken.

Once the salt content of the dict is limited to about 1 or 1.5 Gm a day, it makes little difference whether the patient is also on an acid-ash diet or whether he drinks 1,500 cc. or 5,000 cc of fluid a day. On a larger fluid intake the patient will excrete more urine, but not much more sodium than on the ordinary intake. The fear of fluid—hydrophobia—should definitely be eliminated by demonstration of lack of persistent rise in weight on adding a few glasses of water or other liquids. What we must instill in the patient's mind is natrophobia—fear of sodium in any form.

Suppose that, notwithstanding bed rest, digi talization, low salt diet, and the proper use of ammonium chloride and mercurials, the patient still remains generally miserable and markedly edematous and cyanotic with venous congection and a large liver? Is there anything else that can be done to reduce the edema safely? My colleagues, Drs Cherkasky and Hellman, have applied the ingenious experimental technic of Darrow and Yannet to remove sodium chloride from the body by instilling several liters of 5 per cent glucose intraperitoneally after removing ascitic fluid *4 The glucose solution is allowed to equilibrate with the blood for two and a half to four hours and then is removed carrying with it many grams of sodium chloride. Usually there is good diures in the next forty-eight hours, since the kidneys excrete the water from

which the sodium has been removed by the peritoneal dialysis

It is possible to lower the serum sodium considerably by this technic without harm to the patient, since he has a large excess of extravascular fluid to prevent the circulating plasma volume from falling to shock levels. Incidentally, the relative comfort of the edematous cardiac patient with a low serum sodium and chloride level explodes the myth of the danger of sodium depletion by rigid diets or vigorous mercurial diuresis. The situation is, of course, quite different in a slightly edematous or a non-edematous or dehydrated cardiac patient, especially in hot weather, or in the terminal cachectic state.

Nephrotic Edema

This type of edema is in some ways much more difficult to manage than cardiac edema. Theoretically, the patient should have a high glomerular filtration, because his renal blood flow is not markedly reduced, if at all, in the earlier stages. The glomerular membrane is not fibrosed enough to reduce filtration, and the decrease in plasma proteins should make filtration easier if the blood pressure remains normal. Yet, in spite of all this, the sodium excretion is reduced and the patient's edema may be very stubborn, even on a low salt intake and after the use of mercurial diuretics.

Obviously, other factors must be operative, especially when, without changes in diet, plasma albumin, or diuretic drugs, there occurs a spontaneous diuresis and loss of edema after weeks or months of little change in weight. No one knows what happens in the kidney or elsewhere to bring about this welcome effect, but there is some evidence that the tubules of a nephrotic patient reabsorb sodium to a greater degree than in the normal or the cardiac patient, and that in a so-called spontaneous remission there is a return toward the normal level. We are utterly ignorant of the details of this process

It goes without saying that, like the cardiac patient, and even more so, the nephrotic patient must limit his salt intake severely In addition there is the added burden of restoring lost tissue protein and body weight, of continually replacing the wastage of proteinuria, and, if possible, though as yet unattainable, the task of elevating the plasma albumin well above the so-called edema level in order to increase colloid osmotic pressure and pull extravascular fluid back into the circulation It must be realized that for every gram of plasma protein lost by proteinuria or malnutration, about 30 Gm of tissue protein disappear 5 Because the plasma and tissue proteins form a joint protein pool, according to Whipple and his associates, any attempt to increase plasma proteins by diet, to be successful, must furnish these 30 Gm of tissue protein for every gram increase of plasma protein A simple example will illustrate the therapeutic problem

Suppose a nephrotic patient has a plasma albumin of 18 Gm per 100 cc instead of the normal 48 Gm per 100 cc, in short, a deficit of 3 Gm of albumin per 100 cc of plasma plasma globulin is normal If his plasma volume is 3 L, he will need 30 × 3 or 90 Gm of plasma albumin to restore a normal level However, before this increase can occur from dietary protem, he must provide 30×90 or 2,700 Gm of tissue protein Assuming that body tissue is 25 per cent protein, the patient must build up at least 4×2.700 Gm of actual tissue and muscle or 10,800 Gm, or about 24 pounds of real brawn, This is all based on the assumptions that proteinuria will not increase as the plasma proteins rise, that regeneration of tissue and plasma protein is proceeding normally in the depleted individual, and that the patient can eat enough calories daily to spare enough protein to permit the continual piling up of nitrogen reserves in the protein pool This is quite an assignment in reconversion, and it is no wonder that a few weeks or months of a high protein diet seems to have so little effect on the nephrotic patient's plasma albumin level

Is there not an easier and more direct way? A biologically economic shot in the arm? Prefabricated human salt-free plasma albumin would seem to be the ideal stuff Given intravenously in hypertonic solution in calculated amount, it should immediately increase the plasma albumin concentration, raise the colloid osmotic pressure, and promote removal of edema fluid fortunately, the powerful colloid osmotic pressure of the injected albumin pulls in enough interstitual fluid into the blood to dilute the protein and reduce the expected increase in plasma albumin concentration Also, much of the injected protein runs out into the urine, and the rest disperses into the tissue fluids, where some is used to rebuild tissue protein, and some is metabolized and excreted as nonprotein nitrogen after the administration of large amounts over a period of weeks that some of the desired effect can be achieved in the adult patient 7. This is a very expensive procedure in terms of human blood when you remember that 25 Gm of albumin require at least 500 cc of plasma or 1,000 cc of To inject 50 Gm daily for two weeks a moderate estimate—means a supply of 28 L or 56 pints of blood Since the effect is only temporary at best, it is clear that there is little justification for the use of this therapeutic measure in the nephrotic syndrome except in infants or young children to tide them over

dangerous periods in the disease, and on rare occasions, its use is justified in the severely under nounshed, totally anorexic adult

More practical measures in the adult are a high caloric, high protein, low salt diet with the use of mercurial dureties, if effective, otherwise, or in addition, the use of potassium intrate in adequate design is generally an effective step. A few injections of gum acacia or gelatin over a short period, as practiced at the Mayo Clinic by Keith and his associates, may start the edema moving but this procedure is not recommended for use by the general practitioner. Ordinary plasma or even concentrated plasma is of little or no value in adults because of the high sedium content and its wastefulness.

The great problem is persuading the patient to eat 3,000 calories daily. All the dietetic arts must be utilized, not merely the science alone. Without the extra calories, the extra dietary protein is largely unavailable for rebuilding tissue and plasma protein, because it is utilized for energy. Protein is an expensive fuel. As in the case of liver disease the calories count heavily

Pre uremic Stages of Renal Disease

When edema develops in the late or preuremic stages of renal disease it is often intractable because of the common occurrence of congestive heart failure on a hypertensive or arteriosclerotic basis superimposed on marked reduction of renal function. Mercurial diuretics are no longer useful and are dangerous if pushed beyond a trial dose The therapy of the patient's acidosis, malnutration and dehydration usually requires the administration of parenteral fluids, and only the finest balance between intake and output can prevent further moreage of edema. This is the one pathologic condition in which edema can be increased by water alone change in the composition of the edema fluid is the usual occurrence, depending on the make-up of the miected solution. For example, the sodium and chloride content of the serum and edema fluid may be markedly lowered by ex cessive infusion of glucose in distilled water, thereby increasing edema and diluting the avail able electrolytes or, in case of increased urine flow, washing them out. The kidney can no longer regulate the chemical composition of the body fluids, and all sorts of bixarre artificial patterns may be produced by administering this or that solution

Cirrhosis of the Liver

The treatment of ascites and edema due to cirrhosis of the liver has been revolutionized by the excellent clinical experiments of Patek and Post and other investigators who have substituted the seven-course dinner for the abdom inal trocar. Now, instead of removing from the body several liters of ascitic fluid and its content of precious plasma protein every few weeks. we make every effort to push into the patient s gnatrointestinal tract calories, protein vitamins day after day, week after week, and month after month The results are often grati the patient's re-accumulation of fluid slows up or ceases entirely, and general nutrition and life expectancy are prolonged, even though hemorrhage from esophageal varices may still terminate the course of the disease. The real lesson to be learned from this therapeutic achievement is the importance of good food in the early treatment of chronic fatty or alcoholic livers and various types of hepatitis, toxic or infectious, years before the full-blown cirrhosis has developed With better methods for diagnosing liver disease and with more attention to early clinical signs of malnutration we should be able to take full advantage of the curative effects of optimal diets Whether, in addition special supplements of choline, methionine, or other lipotropic agents or liver extracts will materially improve the results, over those obtained from diet alone, still remains to be shown.

When parenteral feeding is indicated in advanced liver disease or when the oral intake of a full diet is difficult to achieve, it may be of considerable value to give enough salt-free human albumin, 25 to 50 Gm daily intravenously, to restore some tissue protein rapidly to elevate the plasma albumin to promote diurens, and to reduce the formation of ascites and edema 10 While this effect is temporary, it is much more marked than in the nephrotic syndrome because there is no proteinuria, ordinarily, in liver disease The injection of protein hydrolysates while furnishing a source of nitrogen for the daily requirements of protein metabolism, will not usually lead to the building up of badly needed plasma albumin. For this specific purpose there is nothing like prefabricated human albumin, expensive though it may be

Diabetic Glomerulosclerosis

In diabetic glomerulesclerosis we find two kands of edema, at times intermingled In younger individuals and in the earlier or intermediate states of the disease, the edema is of a nephrotic type correlated with marked protein uria and hyposibuminemia. Renal and cardiac function are still relatively good, although hypertension and diabetic retinopathy are usually present. In older subjects the clinical picture is regularly compilicated by congestive heart failure of hypertensive or arteriosclerotic origin and by more or less severe degrees of renal insufficiency

In this group, edema is likely to become as intractable as in any other combination of cardiac and renal failure. The treatment then becomes essentially that of chronic uremia, not a very pleasant task

In the younger diabetic group with nephrotic edema, the same principles of therapy apply as in any other nephrotic edema low salt, adequate protein, high caloric intake, and judicious use of diuretics

In addition, diabetic management is maintained, since, contrary to what some physicians have believed, glycosuria does not lead to removal of edema and sodium from the body unless ketosis is allowed to supervene should be remembered that in some diabetes with considerable peripheral vascular disease and neuropathy or myelopathy, there may be persistent edema of the feet due largely to local neurocirculatory disturbance, aggravated by unrecognized mild congestive heart failure patients may also have some proteinuria due to renal arteriosclerosis, but little or no decrease in plasma albumin Obviously, this edema is not nephrotic and will not respond to dietary measures, apart from restriction of sodium

Other Types of Edematous Conditions

In the persistent edema, caused by constrictive pericarditis, it is obvious that surgical removal of the thickened pericardium is the only measure that promises permanent relief. If this cannot be done, or if this fails to achieve the desired result, the future treatment is essentially the same as for chronic congestive heart failure, excepting for the use of digitalis. However, with an early diagnosis and experienced surgery, only a few of these patients will not respond dramatically.

The edema of myvedema is intractable only so long as the diagnosis has not been made. This can be a surprisingly long time

Scleredema is a mysterious condition, probably the result of an unusual allergic reaction to an acute infection, distressing and disfiguring while it lasts but, fortunately, subsiding spontaneously in most of the reported cases after some months or years ¹¹

We know so little about the mechanism and treatment of steroid hormonal edemas such as occur in pregnancy, in the Cushing syndrome, in certain ovarian disturbances, and in other rarer situations, that it is perhaps just as well that there is no time left to discuss them in detail Whether insufficient inactivation of steroid hormones or pituitrin by a diseased or malfunctioning liver also plays a role in hepatic, cardiac, and nephrotic edema is still a matter of conjecture and not of fact. It is to be hoped that some of these problems will be settled in the near future.

100 EAST GUN HILL ROAD

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TEAM OF EIGHT DOCTORS TO PUERTO RICO ON MEDICAL MISSION

Eight physicians, including one from New York, left on January 20 for Puerto Rico to participate in a medical mission sponsored by the U.S. Department of Interior in cooperation with the A. M. A.

Three Chicago physicians, all associated with the University of Illinois College of Medicine are in the group Dr Ernest E Irons, Dr John B Youmans, and Dr H N Sanford The others are Dr W L Benedict of the Mayo Clinic, Rochester, Minnesota, Dr G M Saunders of the Washington University School of Medicine, St Louis, Dr E C Person of the Cornell University Medical College, New York, Dr John H Willard and Dr E D Bond, Philadelphia

Miss Edna Newman of the Cook County Hospital School of Nursing, Chicago, will accompany the mission as a representative of the nursing profession

The purpose of the mission will be to investigate the medical services now available for the indigent in Puerto Rico, and to submit recommendations for the improvement of those services

The medical investigators also will visit the Virgin Islands

Dr Youmans, in addition to participating in the mission, will conduct experiments on tropical sprue (a chronic disease which causes emaciation, anemia, and, frequently, death) in Puerto Rico—A.M.A. News, January 23, 1948

RINGWORM OF THE SCALP IN NEW YORK

ROTAL M MONTGOMERY, M.D. JOHN A HEINLEIN, M.D. and Frances E Karpluk, B A New York City

(From the New York Skin and Cancer Unit, Department of Dermatology and Syphilology New York Post Graduate Medical School and Hospital)

THERE have been many recent reports of epidemics of tines capitis throughout the United States.¹⁻⁴ Most observers have found Microsporon audouini to be the most prevalent causative organism, although there have been studies in different localities which have shown other funct to be the causative factors.⁴

For the purpose of comparison and in order to supplement the existing reports, a statistical study of the cases at the New York Skin and Cancer Unit was made with the findings reported here.

During the eight year period of 1940 to 1947, 2,857 cases, of which 2,379 (83.8 per cent) were caused by M audoumi, of timea capitis were treated in this clinic. During 1941 and 1942, there was a gradual increase in the incidence of M audouini infections. A sharp rise of tinea capitis cases occurred in 1943, accompanied by an abrupt relative increase in the percentage of cases caused by M audoumi This high level has been maintained and demonstrates that the epidemic in New York City and the surrounding area has not abated In 1946, 587 cases of ringworm of the scalp were treated, of which M audoum was the causative fungus in 502 or 85.5 per cent. In 1947, 528 cases were treated, 826 per cent of these were caused by M audonini.

Table 1 lists by years the various organisms found and the number of cases caused by each

In addition to the high incidence of M. audou inl, it will be noted that our series includes 3 cases caused by Trichophyton crateriforms and 4 cases from which T sulfureum was isolated Achorion schoenlenn and T violaceum were more prevalent than the other endothrix organisms just mentioned There were 4 cases of eyelash infection during the eight year period all were caused by M audouni.

In I case of tinea capitis, fuseaux-like bodies on the infected hair shaft were noticed. At different visits microscopic examination of a sodium hydrovide preparation of the hair showed these fuseaux-like bodies. This had not been previously observed at the New York Skin and Cancer Unit. Although Benham, Hopper, and Delamater have verbally mentioned observing them, no reference in the literature to the presence of these bodies on direct examination of fungous-infected hairs has been found.

Further examination and study is necessary to determine whether these bodies are in reality fuscaux or whether they may be epithelial cells or other formations which have split off from the cortex of the hair itself (Fig. 1)

Summary

- 1 From 1940 to 1947, inclusive, 2,857 cases of tinea capitis have been studied at the New York Skin and Cancer Unit. Of these, 83.8 per cent were caused by M audouini
- 2 There has been a sharp increase in ring worm of the scalp since 1043, and a substantial relative increase of infections by M. audouini
- 3 Three cases of Trichophyton crateriforme, 4 cases of T sulfuroum infections of the scalp, and 4 cases of M audouin infections of the eyelashes are reported
- 4 Fuscaux like bodies were observed on direct examination of hairs in 1 case of M audourn infection of the scalp

57 West 57th Street 999 Fifth Avenue 301 East 19th Street

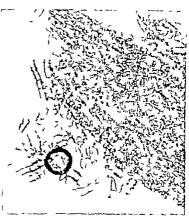


Fig. 1. Injected hair showing sheath of spores and fuseaux like bodies at the cortex. These bodies are not regularly shaped nor do they show uniform septa.

TABLE 1 -FUNGI FOUND IN TIMEA CAPITIE AT THE NEW YORK SKIN AND CANCER UNIT

Organism	1940	1941	1942	1943	1944	1945	1946	1947	Total	Percentage
Microsporon lanosum	24	28	26	55	63	65	80	53	394	13 8
Microsporon audouini	29	53	65	489	365	421	502	455	2379	83 3
Trichophyton violaceum	Ų.	ž	2	2	2	Ų	ñ	ò	13 16	0.6
Achonon schoenleini Trichophyton crateriforme	ų.	0	1	Ÿ	ก	ስ	ň	ก็	3	0 1
Trichophyton sulfureum	ŏ	Ô	ô	Ô	ĭ	ŏ	ĭ	ž	ă	ŏî
Microsporon fulvum	ŏ	Ō	Ō	2	0	1	1	0	4	0 1
No growth or not diagnosed	3	1	0	26	0	0	1	13	44	15
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Total	57	90	99	575	433	488	587	528	2857	

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MAYOR O'DWYER URGES STUDENT NURSE RECRUITMENT IN ILLUSTRATED HOSPITAL DEPARTMENT BOOKLET

In its intensive drive to recruit additional graduate nurses and more students for it snursing schools, the Division of Nursing of the Department of Hospitals, on January 19 began the distribution of 20,-000 copies of a 32-page illustrated booklet with a foreword by Mayor William O'Dwyer, urging young people to consider nursing as a career The Mayor's statement follows

No profession today offers fuller opportunities for young people than nursing Salary levels have been raised and the nursing service in our municipal hospitals now enjoys a 40-hour, five-day week. But beyond that I know of no work that is more soul satisfying than the inner reward that comes from ministering to the sick and distressed, for this is truly one of man's nobler callings vast new horizons open to nurses in hospitals, public health, and industry, the need today is The enrollment of student nurses now will mean more graduates to fill the increasing number of job opportunities that present themselves in both the professional and practical nurse fields I sincerely hope this brochure will present a full picture of nurse training to you so that you may choose nursing as a career

Text and pictures outline the work and recreational activities of student nurses in the Department's six professional schools of nursing, as well as for its practical nurse school on Welfare Island, give entrance requirements, opportunities for the graduate and the cultural and educational advantages of New York City as a training center

The 27 municipal hospitals and homes of this city have a total of 2,314 graduate nurse vacancies and a minimum of 600 more students can be trained in the Department's nursing schools Enrollment in the graduate nursing schools has fallen to 396 students in 1947 from a high of 588 students in 1945, the final year of enlistment in the U.S. Cadet Nurse Corps through which nurse training was subsidized by the Federal Government Nationally, student enrollment dropped to about 40,000 in 1947, from 56,567 ın 1945

The nursing booklet may be obtained free by writing to Mary Ellen Manley, R.N., Director, Division of Nursing, Department of Hospitals, 125 Worth Street, New York City 13, or by calling WOrth 2-4440, Extensions 515 or 516

The recruitment campaign is under the supervision of Hazel Houston, R N, of the Nursing Division

UNION INCREASE UNNECESSARY FOR MEDICAL CARE

It is understood that the United Automobile Workers Union is asking a 30 cents per hour increase in pay for its members, 25 cents of which is to cover the higher cost of living and five cents to cover "medical care"

On the basis of a 37-hour work week, this "medical care" fund would total \$96 20 per year for each employee AMA insurance experts are wondering if union employees have overlooked the fact that they can get very good prepaid coverage for them-selves and their families for this amount Several of the very good medical and surgical insurance plans now available cost much less than \$96 20 annually -Secretary's Report, A M A, February 9, 1948

VIRUS MENINGITIS AND INFECTIOUS MONONUCLEOSIS

STEPHEN B PAYN M D . New York City

(From the Lebanon Hospital, Department of Medicine Service of Dr S Gillow)

THERE seems to be hardly anything in com-I mon between virus meningitis and infectious mononucleosis, yet it may sometimes be necessary to make a differential diagnosis between the two conditions.

Virus, or lymphocytic meningitis was first described by Wallgren in 1925 as acute aseptic meningitis 1 It is characterized by an acute onset with headaches, vomiting fever nuchal rigidity and lymphocytic pleocytosis. In this description there is, indeed, very little that would remind one of infectious mononucleosis with its lymphadenopathy, splenomegaly, and characteristic blood findings Sometimes, how ever, infectious mononucleosis may be complicated by meningeal manifestations

The first clear descriptions of neurologic com plications in infectious mononucleosis were given in 1931 by Epstein and Dameshek and by Johansen 12 Since then, a number of other reports have appeared Their similarity to lymphocytic meningities is striking. Referring to this similarity Epstein calls attention to the fact that there are systemic, as well as blood, diseases which show central nervous system involvement 4 He believes that infectious mononicleous may produce cerebral changes, and conversely, that lymphocytic meningities is merely a manifestation of some, as yet unknown, systemic disease Zohman and Silverman point out that many virus diseases are, in some instances, complicated by encephalitis and myelitis, an indication that the virus has acquired neurotropic properties. They assume that the virus of infectious mononucleosis also becomes neurotropic sometimes

It would be interesting to know whether there are any spinal fluid changes in cases of infectious mononucleosis which do not show any symptoms Thelander or signs of meningeal involvement and Shaw found several reports—in the literature on the subject and in personal communications to the authors—to the effect that the spinal fluid in such cases was normal. However, Schmidt and Nyfeldt saw 3 patients with infectious mononucleons whose spinal fluid showed an increased number of cells even though there was no clinical ovidence of central nervous system disease 7

Because of the possibility of meningeal involvement in infectious mononucleosis, many authors advise that this diagnosis be considered in every case of virus meningitis Tidy goes even further \$ He points out that the symptoms course prog nosis and spinal fluid changes in lymphocytic meningitis and in the neurologic manifestations of infectious mononucleous are identical literature he did not find a single report of a case of lymphocytic meningitis in which infectious mononucleosis was even mentioned, let alone excluded, and he insists that in the presence of neurologic symptoms, infectious mononucleosis can be excluded only by the heterophile agglutination test.

The question arises as to whether a positive heterophile agglutination test alone is sufficient evidence for the diagnosis of infectious mononu cleons Kaufman states that an increased heterophile antibody reaction may occur in diseases other than infectious mononucleous and mentions a case of Hodgkin's disease and a case of rubella. Kent reports a positive heterophile reaction in a patient with leukemia and raises the question as to whether the case represents a "false" positive reaction or leukemia with super imposed infectious mononucleosis 10 That in jections of horse serum will produce a positive heterophile antibody reaction is well known, but there are ways of differentiating heterophile agglutinations due to infectious mononucleosis from those due to other conditions According to Kaufman, the present concept recognizes that there are 3 types of sheep cell agglutinins those in normal serum, which are absorbed by guineapig kidney but not by boiled beef erythrocytes. those in the serum of patients with infectious mononucleosis, which are absorbed by boiled beef erythrocytes but not by guinea pig kidney, and those in the serum of patients treated with horse serum which are absorbed by both guinea pig kidney and beef erythrocytes

These absorption tests were performed in the case presented here

Case Report

Case 1 -A 22 year-old white girl developed general malaise rather suddenly with temporal and compital headaches, aching in her back and legs, and fever ranging between 101 and 102 F (rectally) On the third day of her illness she had a chill The headaches became more intense and in addition, photophobia became a prominent symptom. The follow ing day she vomited undigested food on several occasions. The physical examination which had shown normal findings up to that time, then dis-The tendon reflexes were closed nuchal rigidity normal Kernig's sign was negative.

The patient immediately received 300 000 units of penicillin in oil and becswax intramuscularly 60

Gm of sodium sulfadiazine intravenously, and 4.0 Gm of sulfadiazine by mouth Several hours later, she was admitted to the hospital

A spinal tap showed clear fluid under a pressure of 100 mm of water, with 96 cells per cu mm, 95 per cent of which were lymphocytes Globulin was The sugar content was 52 mg per 100 cc No organisms were found on smear or culture blood showed a hemoglobin of 136 Gm. and 7,700 white blood cells with 56 per cent polymorphonuclear leukocytes, 2 per cent eosmophile leukocytes, 4 per cent band forms, 1 per cent juvenile forms, and 37 per cent lymphocytes A week later, there were 9,900 white blood cells with 58 per cent polymorphonuclear leukocytes, 2 per cent eosinophile leukocytes, 2 per cent band forms, 3 per cent juvenile forms, and 34 per cent lymphocytes On the tenth day of illness the heterophile antibody test showed agglutination in 1 40 dilution Thirteen days later, the titer was 1 80

Under palliative treatment the symptoms and signs subsided, and the patient was discharged ten

days after admission

Two months later the heterophile antibody reaction was repeated with the absorption tests results were as follows nonabsorbed, agglutination in 1 56 dilution, after absorption with guinea-pig kidney, no agglutination, after absorption with boiled beef erythrocytes, agglutination in 1 28 dilution * In other words, the antibody for infectious mononucleosis was not present

Comment

This is a patient who presented the symptoms, signs, laboratory findings, and course of virus meningitis There was no enlargement of lymph The blood picture was essennodes or spleen tially normal, and yet, the heterophile antibody reaction was positive in low but increasing titers After two months, heterophile agglutination was still present, but absorption tests showed that the antibody for infectious mononucleosis was not present According to Thomson this may occur in infectious mononucleosis at the beginning of the disease, at the end of the disease, or if there has been any other intercurrent febrile disease 11

In the case presented the absorption tests were done two months after clinical recovery Furthermore, the patient had had an upper respiratory tract infection about three weeks before the tests were performed Therefore, no conclusions can be drawn from this case It would be interesting. however, especially in view of Tidy's paper, to observe how often a positive heterophile antibody reaction occurs in virus meningitis, and what the absorption tests show in such cases 8

Summary

Infectious mononucleosis may be complicated by meningeal manifestations and may then present the same clinical picture as virus menin-The heterophile antibody reaction should, therefore, be performed in all cases of virus meningitis It should, however, be supplemented by absorption tests in order to detect agglutination due to conditions other than infectious mononucleosis

A case of virus meningitis is presented which showed a positive heterophile agglutination reaction, but in which the absorption tests suggested that the antibody for infectious mononucleosis was absent Because of interfering factors, no conclusions can be drawn in this case from the result of the tests It would be interesting to note the results of these tests in other cases of virus meningitis

2491 DAVIDSON AVENUE

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^{*}With the technic employed (Dr Annis E Thomson's five-minute modification of the Davidsohn method¹¹), a titer of 1 28 in nonabsorbed serum and a titer of 1 14 after absorption is considered positive.

The author wishes to thank Dr S Gitlow for his kind advice,

HYDATIDIFORM MOLE IN PRIMIGRAVIDA

FRANCIS A SMITH, M.D., F.A.C.S., Buffalo New York

MARCHAND was the first to establish the fetal origin of hydatidiform mole and later, Ewing related that a teratomatous origin was also likely in very young or old individuals exhibiting this condition. The cases to be presented here are two young women, primigravida, in their early twenties. The first case suffered from a pilonidal cvst but was otherwise well. The second case had enjoyed average good health up to the onset of her present illness.

Conservative therapy was employed in both these cases because of the possibility of future preg nancles Had they been treated by abdominal operation leaving a scar in the uterine musculature the risk of rupture of the uterus would have been present in all subsequent pregnancies. Thus, nor mal childbirth following the mole might have been supplanted by cesarean section, or even worse, spontaneous rupture of the uterus with fetal and

maternal catastrophe.

Therapy was instituted as soon as the diagnosis was made and consisted of evacuation of part of the mole through the slightly dilated cervax uteri the insertion of a pack, and the oral administration of ergotrate and stilbestrol for twelve to eighteen hours. During this preoperative treatment which controlled the hemorrhage the patient s blood was studied, and whole blood infusions and adequate fluids were given. When the patient was in good condition, she was removed to the delivery room, was prepared and draned as for vaginal surgery and was anesthetized The cervix was exposed and if necessary was gently dilated to two fingers width. A sponge forceps was then inserted and the uterus slowly emptied of its contents. As the size of the uterus decreased ergotrate was given intravenously Signs of fresh hemorrhage were an indication to wait for further uterino contraction before proceeding with the ovacuation.

After the uterus reached such a size that the fundus could be palpated digitally via the cervix, the uterine wall was examined digitally in an attempt to locate any areas of infiltration of the uterine musculature. One cannot be too cautious or too gentle in this procedure. Since none were felt in either of these cases the uterine wall was gently curetted by the examining finger and all loose mole removed. The well-contracted uterus was then lightly curetted with a flat rounded Thomas curet, and a sulfanilamide-imprognated pack was placed firmly in the uterine cavity cervix,

and vagina.

Postoperatively the patients received additional blood and fluids plus ergotrate and stilbestrol. The convalescence of one patient was stormy while that of the other was dramatic in its suddenness. The packs were removed in twenty-four hours and the ergotrate and stilbestrol continued until involution was firmly established, and the lochia was at its physiologic minimum. Friedman tests were made until two successive negative tests were reported.

Case Reports

Case 1 —Mrs. A. R. was a 21 year-old white woman. She had had no provious illness except a pilonidal cyst which had become infected in several occasions. Her present condition dated from Decomber 10, 1941 which was her last normal menstrual On January 23 1942, she began to flow vaginally every three or four days. Associated with the amenorrhea was a marked nausea and vomiting with severe weight loss. On February 27 she flowed heavily and was admitted to the Buffalo General Hospital on March 1

Examination revealed a uterus the size of a five months pregnancy (Previous examination in Jan uary rovealed a uterus the size of a three months pregnancy) Y ray examination showed no evipregnancy) X ray examination showed no evidence of a fetus and the Friedman test was positive in a 1 10 dilution At this time a diagnous of mole was considered as most likely but was not proved The bleeding subsided, and the patient was dis-charged on March 5 1942.

On March 20 she again began to hemorthage and had a sudden profuse episode of bleeding. She was hospitalized again and given 500 co. of woole blood. Examination showed the uterus enlarged to size of seven months' pregnancy On March 21, she again bled severely and was removed to the delivery room and examined under aseptic conditions A small amount of mole was removed and the cervix, which was one finger dilated was packed. She was given 500 cc. of whole blood and prepared for surgery The following morning, under gas and oxygon anes-thesis, the mole was ovacuated with a sponge for ceps. Intravenous ergotrate was given, and when the uterus was contracted sufficiently the wall was curetted digitally. The uterus was then tightly packed and the patient returned to her room

The postoperative course was febrile for four days with two chills and a high temperature of 105 F The patient was given 1 750 cc. of whole blood and improved rapidly She was discharged on March 31 in excellent condition

Case 8 -Mrs. M R. was a 22-year old white woman of average size and weight. She was first seen on February 7 1947 and gave a history of marked nausca and vomiting with noticeable weight loss. Her last period was November 23 1946 She also reported 'spotting' for the past week. Her physical examination was negative weight 125 pounds and blood pressure 110/70 She was not examined believally because of her spotting. She was advised to rest and report any further bleeding. The following day February 8, 1947 she again flowed and was hospitalized. She continued to flow slightly even with bed rest, and on the third day a polvic examination was made which revealed a uterus the size of a three months pregnancy. Two days later she was discharged unimproved and advised to rest at home. Her "spotting continued and with it she developed a severe backache.

On the day she was due to return for a prenatal visit (February 19 1947) her husband reported that she had such a severe backache and such enlargement of her abdomen that she could not get about.

was good

She was again hospitalized, mainly because of the remark about her enlarged abdomen. Shortly after admission to the hospital, she had a sudden severe hemorrhage and was removed to the delivery room. Examination revealed a uterus the size of a six and one-half months' pregnancy, very tense and tender A diagnosis of mole was made.

Under intravenous pentothal, pelvic examination was performed. The cervix was anterior and one finger dilated. The examining finger was inserted into the cervix, and about a cupful of mole gently expressed. A sulfanilamide-impregnated pack was inserted into the cervix. The patient was returned to her room, given ergotrate, stilbestrol, 250 cc of plasma, and 500 cc of whole blood. Her condition

The following morning the patient was again anesthetized with intravenous pentothal cervix was slightly dilated and extraction of the mole begun with a curved sponge forceps As the uterine cavity was slowly emptied, an ampule of ergotrate was given intravenously After the bulk of the mole was removed, a finger was inserted into the uterus and the uterine wall palpated Since no soft areas were found, the wall was curetted with the examining finger Also, since there was no evidence of infiltration of the uterine wall, a flat, rounded curet was introduced and a gentle curettement performed so that the uterine wall was cleaned of all mole After completion of the curettement, a sulfa pack was again inserted, and the patient was given ergotrate and stilbestrol orally Further blood studies were conducted and adequate measures taken

Recovery in this case was very sudden. The patient was "well" in twenty-four hours and was free of any toxic symptoms. The pack was removed, and no further hemorrhage occurred. Friedman tests on March 19, 1947, and again on May 12, 1947, were negative. Pelvic examination was also negative.

Comment

Certain symptoms and signs were markedly evi-

dent in both of these cases. Both patients complained most bitterly of nausea and vomiting with more severe loss of weight than is usual in normal pregnancy. Associated with these symptoms was frequent "spotting". I feel that any patient exhibiting this combination should be carefully observed and not be dismissed lightly as neurotic

Rapid increase in the size of the uterus with abdominal discomfort and a feeling of constriction appeared in both cases but after the previously mentioned signs and symptoms However, this combination, plus severe nausea and vomiting, weight loss, and "spotting," favors the diagnosis Possibility of error may be checked by Friedman tests and x-ray which have a negative value in that they show neither chorionic villi present (negative Friedman) nor a fetus (normal pregnancy) examination, demonstrating the hydatid mole, is the final confirmation and can be made only when the patient passes mole tissue, or the examining finger is introduced into the uterus Therefore, all precautions must be taken and the patient closely observed to avoid interrupting a normal pregnanci or a normal pregnancy complicated by premature separation of placenta in the second trimester

Hemorrhage is the most dangerous immediate complication, and it demands prompt, adequate attention. The early external bleeding is not severe, but later, considerable occult bleeding occurs in the uterine cavity and is expelled suddenly when sufficient pressure is present to dilate the cervix forcefully. This probably accounts for the geyser-like quality of the bleeding. It is extremely important to replace the lost blood with whole blood. Plasma and aqueous solutions are useful in the emergency, but neither have any hemoglobin-carrying capacity and are no substitute for whole blood.

305 ELMWOOD AVENUE

HOW THE ENGLISH DOCTOR RELAXES

(Letter in the London Times)

To the Editor During the last seven days, in addition to my ordinary daily work as a country doctor, which means long hours of motoring, visits, and surgery attendances, I have been called upon to issue medical certificates for (1) vacuum flasks, (2) corsets, (3) coal, (4) brassieres, (5) hot-water bottles, (6) elastic stockings, (7) outside shoes, (8) milk, (9) eggs, (10) clothing coupons for expectant mothers, (11) oversea travel, (12) successful vaccination and inoculation, (13) children's family allowance, (14) glucose, (15) Horlicks, (16) brandy, (17) whisky,

(18) petrol, and (19) paraffin Further to this, all my "panel" patients when sick demand a duplicate certificate for their employer if they are employed in any government or municipal work, otherwise they lose some of their sick benefit

My real work—treating the sick—is becoming of

secondary importance

Yours faithfully, R O Townend Swaffham, Norfolk

-J A M.A , January 24, 1948

ANAPHYLACTIC SHOCK DUE TO NICOTINIC ACID

S K. Fineberg M D . New York City

NICOTINIC acid is assumed to be a nontoxic substance Chen Rose and Robbins deter mined the lethal dose for dogs to be 2 000 mg. per Kg. of body weight given over a puriod of eight to ten days! Until recently the only untoward effects which had been encountered in the course of either oral or intravenous therapy with this drug were the flushing of the skin and sensation of warmth which almost uniformly follows its administration.2.2 These symptoms have rarely given much cause for alarm. On the contrary the vasodilatation of the peripheral and deep blood vessels, causing these symptoms has given rise to the widespread use of nicotinic acid for that very effect in peripheral vascular diseases and many others, in eluding angina pectoris in fact this vasodilatory action of micotinic acid is employed even more than the drug's specific action in pellagra * 5

However the belief in the complete innocuousness of this substance has recently been shaken by a report of the production of anaphylactic shock in 2 patients. In both of these cases allergic reactions to an oral dose had been experienced before they received the intravenous dose which precipitated the anaphylactic shock. In the case to be described, shock was experienced thirty-six hours after the institution of large repeated doses of nicotinic acid by the oral route only The drug was prescribed in this manner for its vasodilating effect in the belief that spasm of the retinal arteries which was producing blurring of vision, might be overcome is interesting to note that the spasm of the retinal vessels in this case was due to a marked drug hyper sensitivity noted four hours after the ingestion of 15 grains of quinine sulfate Ironically it was learned, after the incident that in 1941 Loman Rinkel, and Myerson performed careful studies of the intracranial vascular effects of nicotinio and and found that the retinal arteries neither dilated nor constricted following its use. They demonstrated that there was no alteration in spinal fluid pressures following administration, nor was there any change in the ratio of arterial oxygen to venous oxygen in vessels leading to and from the cerebrum thereby proving that nicotinic acid is ineffective as a cerebral vasodilator

Case Report

S. F., a 32-year-old veteran, was given 15 grains of quinine sulfate twenty four hours after the institu tion of atabrine therapy for a relapse of malarial fever. No further doses of quinine were given bo-cause of the development of severe timpitus, marked deafness and night blindness within four hours of the first dose Twenty-four hours later the patient complained of blurring of vision, mainly of the left

Nicotinic acid, 150 mg three times a day was prescribed in the belief that possible permanent damage to the retina would be averted Forty five minutes after the ingestion of the sixth dose of nicotinic acid, the patient noticed substernal tightness and burning, followed by tachycardia cardiac irregularities and a

rapidly developing weakness. Within twenty min utes the patient was completely prostrated, although conscious, and was complaining of coldness and numbness of the extremities. The pupils were dilated widely the pulse was 130 and was thready and somewhat irregular and blood pressure was The skin was cold and pallid. Respirations were gasping in character and a state of collapse was obvious Three minims of epinephrine in a 1 1 000 solution were given. The patient was placed in the Trendelenberg position and warm blankets applied Gradual relief of symptoms was noted, only to be followed in about two hours by a recurrence of similar but milder, symptoms. The following day the patient was well and had no complaints except for some slight weakness.

Examination of the past history revealed that the patient had been on suppressive antimalarial therapy with both atabrine and quinine while over sens in malarial areas. In the past year he had doveloped a severe, chronic urticaria and had had fre quent attacks of angioneurotic edema Frequent unexplained, short attacks of sovere abdominal colic accompanied by nausca and vomiting had also been noted during that period The patient had never knowingly taken nicotinic acid per se before stated that occasionally he would take a multivitamin "perle for a day or two when he felt his diet

was not entirely adequate.

Six weeks later the patient was given an intra-dermal skin test using 0.05 cc of a solution of nicotinic acid containing 10 mg per ce. A large wheal with pecudopodia surrounded by a zone of crythema developed within ten minutes. The reaction reached its height in forty minutes, at which time the wheal measured 2 cm in diameter and the zone of crythema A control of 0 05 cc. of normal 4 cm. in diameter saline was placed into the skin of the other forearm and in addition, a similar skin test with the nicotinic acid solution was performed on 1 other individual No reactions were noted in the control areas

Comment

Through the investigations of Landsteiner and his coworkers, allergies due to drugs and toxoids are now considered the result of an antigen-antibody reaction.7 They are due to chemically modified proteins (conjugated proteins or haptens) which become antigenic combinations capable of sensitizing the host just as any other antigen. A. hapten is a nonprotein substance usually of lowmolecular weight which when combined with protein material forms a new antigen. Haptens may be simple drugs or complex compounds like the specific soluble carbohydrate of the pneumococcus which when combined with protein forms a new protein which is specifically antigenic. Once sensitization has been brought about by the combined. hapten-protein, the hapten alone may produce an allerenc reaction Crossed reactions may occur with haptens also

It would appear that in the case reported nicotinioacid, acting as a hapten, combined with a body pro-Either unusually rapid response or sensitization to this combination followed so that in less. than forty-eight hours the continued ingestion of nicotinic acid brought about anaphylaxis, or else the patient had been sensitized previously by taking small doses of meetinic acid or macinamide in a multiple vitamin preparation

Summary

A case of anaphylactic shock due to oral nicotinic acid administration is reported

When collapse is encountered in the course of therapy with micotimic acid, the strong possibility that it is anaphylactic shock due to that drug should be considered and epinephrine administered without delay

Some caution should be exercised in the use of this drug to anticipate a possibly severe reaction. particularly in allergic individuals

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AN UNUSUAL LOCAL REACTION FROM SMALLPOX VACCINATION

Michael A Brescia, M.D., Corona, New York

(From the Pediatric Departments, St. John's Long Island City and Willard Park Hospitals)

HIS case of smallpox vaccination is reported because of the unusually large local skin reaction which was obtained

Case Report

A married woman, 56 years of age, was vaccinated on the outer surface of the left upper arm on April 10, 1947, by the multiple puncture method She had been vaccinated successfully once before during childhood The history was irrelevant and

negative with regard to allergies
On April 18, the patient had a slight chill and fever with some soreness of the left arm and axilla At this time, there was a primary reaction, showing a crusted area 2 cm in diameter Within twenty-four At this time, there was a primary for crusted area 2 cm in diameter. Within twenty-four hours, on April 19, a large doughnut shaped vesicle developed around the crusted lesion. The vesicle management and measured 6 cm in diameter. There was very little pain around the lesion, and the pain in the axilla had subsided There was no inflamma-

The picture (Fig. 1) was taken on April 20 the posterior dependent part of the vesicle, some fluid was seeping out, but there was no spread of the lesion

tory reaction beyond this vesicular lesion

At this time the type of treatment was considered. The question of giving penicillin was raised, but since there were no constitutional reactions, it was withheld

The lesson was of some concern to the patient but otherwise did not give rise to any symptoms Hence, expectant treatment was the course followed Soon the vesicular fluid became cloudy and was

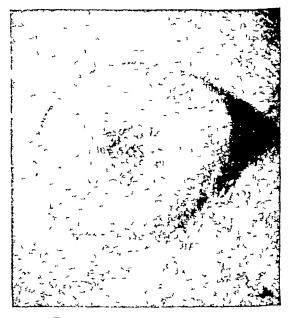


Fig 1 —Frontal view of the lesion

absorbed eventually By May 2, there was a large loose crust about the size of a half dollar which the patient shed in a few days

40-50 JUNCTION BOULEVARD

CONGENITAL URETEROVESICAL JUNCTION STRICTURE SIMULATING THE ACUTE ABDOMEN

ROBERT V SCHATKEN M.D., Walton, New York

THIS case is reported in order to illustrate the pit falls that await the general surgeon if he does not keep in mind constantly the ever present possibility of disease or mailtormation of the genitourinary organs which so commonly simulates the acute abdomen.

In the examination of a patient with the main complaint of acute abdominal pain, it is common knowledge that many purely medical conditions, acute diseases of the female genital system and cer tain physiologic unsets must be considered and discarded in order to diagnose accurately the acute surgical condition. It is well known too but probably less appreciated, that certain conditions of the genitourinary tract may simulate the abdomen at times. The latter is considered less often in the differential diagnosis and frequently the examination of a routine urine is a sufficient reason to rule out genutourinary disease completely. This holds particularly true in rural areas where the opportunity for extensive and detailed examination is more difficult to obtain. The fact that a normal urine does not rule out disease of the urmary tract is borne out by this case report.

In reviewing the literature, one finds an abundant amount of material on stricture of the ureter in general. In several textbooks the etiology of stricture of the ureter is divided into congenital and acquired stricture but the former is mentioned only in passing. One is more apt to think of this condition if other pelvic pathology is present or if there has been an antecedent injury operative or otherwise Given a patient who has never been operated upon never had an acute abdominal injury or who has not had repeated instrumentation of the uretors the diagnosis of stricture of the ureter is not often considered. Campbell has reported on congenital bu lateral ureterovesical junction strictures in infants.1 He has collected 15 cases and states that the ultimate result is always the same the symptoms and physical signs being those of back pressure and urinary infection Other reports concern themselves with ureteral strictures, in general, mostly not of the congenital type

Case Report

This patient is a 36-year-old white man who for eight years had complained of recurrent attacks of pain in the right lower quadrant. The attacks occurred on the average of about every two months. He described the pain as piercing. The pain would last usually one day, was intermittent and was not of the colle type. When the pain subsided the right lower abdomen would remain sore for a time. He was generally symptom free then, until the next attack except for a vague feeling of not being well. There was never any nauses or vomiting, and as far as he know he had never had any fever with the attacks. He was seen on several occasions during the attacks and was told he had acute exacerbations of a chronic appendicitis. On several occas

sions an appendectomy was urged which he had nover had He was hospitalized once several years ago A blood count and urine analysis were found to be within normal limits and a barium enema was normal Nothing elso was done in the nature of a

diagnostic examination.

The October 1946 while watching a football game of he became nausous for the first time but had none of his usual pain. The nauses became progressively worse, and he left the football game and started to drive home in his car. He apparently fainted while driving and crashed his car into a store window fortunately burtung neither himself nor anyone else He was unconscious for several minutes and when he awoke he had severe pain in his right lower quadrant. This pain was the same as he had always had with his attacks but much more severe. He was exactly similar in type to the right lower quadrant pain and stated that when his flank pain began the right lower quadrant pain and stated that when his flank pain began the

right lower quadrant pain mostly disappeared. I saw him for the first time about thirty minutes after his accident. He was lying in bed groaning with pain which was present mostly in the left flank. The pain was constant, with occasional exacerbations. It did not radiate to the thigh, testicle or abdomen. He appeared pale and acutely ill. Temperature was 100.2 F orally. His blood pressure was 122/74 the pulse rate was 83, regular and of good quality. Examination was completely within normal limits except for some tenderness in the left flank and considerable tenderness over the entire lower abdomen particularly in the right lower quadrant. Voluntary rigidity was present over the entire abdomen, but the patient was in such pain that the significance of this latter finding was held in aboyance. Urine examination was completely negative, and a white blood count showed 9 800 cells with a normal differential count.

No sedatives were given and the patient was seen again three hours later at which time he was more comfortable, although the tenderness was still present in the right lower quadrant and to some extent over the left flank. It was felt at this time that he did not have an acute surgical abdominal condution. The following day he was greatly improved with no

medication.

Several days later, he was hospitalized Urine analysis and complete blood count tests were entirely normal. A gastrointestinal series was normal except for a report of considerable spasticity involving the descending colon. A barium enema showed nothing abnormal An intravenous pyelogram visualized two normal kidneys with 'marked dillatation of the ureters on both sides, much more marked on the left, consistent with hydroureters (Figs. 1 and 2)

The patient was systoscoped by Dr Henry Marshal who reported the following pertinent find nigs and procedure "The right unterral orlice was normal in location and was approximately 2 mm. in length The loft unterral orlice was plinbole in size although normal in location. The upper portion of the uneteral ridge appeared enlarged. The posterior urethra, vesseal neck, trigono, and bladder were



Intravenous pyelogram fifteen minutes after injection of diodrast Note great enlargement of lower end of left ureter with moderate enlargement of right ureter

The left ureteral orifice was incised with normal cystoscopic scissors for a distance of 1.5 cm lowing this procedure, the opening was dilated until it admitted a French 12 bulb catheter without diffi-The right orifice was similarly incised for 1 culty cm with dilatation to French 12

Note was made of the fact that there was no particular bleeding, probably due to the fact that the cut mucosa appeared fibrous in nature "

At the time of this writing, more than four months has elapsed, during which time the patient has remained entirely well Almost directly following this cystoscopic procedure, the patient stated that he "knows he is cured." He felt "different" from any time in the past eight years Follow-up urine



Same series as in Fig 1, taken one hour Fig 2 after injection of diodrast There is no further visualization of right ureter with diodrast still present in left

examinations have been consistently free of pus and blood

This case is reported as a reminder to anyone who has occasion either to see or to operate on the "acute abdomen" It is necessary that one keep in mind the fact that lesions of the genitourinary tract can and do cause abdominal pain and can simulate almost any acute abdominal surgical condition A negative urine examination does not rule out disease or defect of this system

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PROMOTE PLANS FOR PUBLIC HEALTH DEPARTMENTS

Dr Dean F Smiley of the A M A Bureau of Health Education, Dr Louis A Bauer, Hempstead, New York, a member of the A M A board of trustees, and Mrs Luther H. Kice, Garden City, New York, president-elect of the Woman's Auxiliary of the A -MA, participated with representatives of 45 other voluntary agencies in a recent meeting held in New York to work out plans for promoting full-time local public health departments

Ten resolutions were adopted, urging that each organization encourage its component state and local branches to work toward the following major

goals

The organization of a local community health council or its equivalent

Local action to urge boards of supervisors and city councils to avail themselves of legislation enabling them to organize local departments of health and receive the assistance of federal and state grants

To urge states to provide more generous subsidies to local counties

Urge passage of the federal bill, sponsored by the National Congress of Parents and Teachers, to assist the states in the development and maintenance of local public health units -Secretary's Letter, A M A , February 9, 1948

PSYCHOSOMATIC RHINORRHEA AND PSYCHOSOMATIC DYSPNEA*

LOUIS STERNBERG M D New York City

(From the Department of Allergy Beth Israel Hospital)

IT HAS been accepted generally that the chief predisposing cause of many allergic manifestations is hereditary The exciting factors vary Bronchial asthma may be classified among others into the inhalant and infective groups has fever into the seasonal and nonseasonal types The local or shock organ reaction is an antigen-antibody reaction which induces a cellular response presumably due to histamine release or to other physiologic changes.

That allergic reactions can be modified and exag gerated by emotional factors is generally accepted. During the past ten years there have been many published references to the effect that psychio trauma can predispose and occasionally may precipitate the signs and symptoms of an allergic reaction.1-4 Those interested in the management of allergic diseases are aware of the fact that excitement, worry overwork, stress and strain do affect the course of these cases and may produce also a symptomatology identical with that of allergic disease One can not agree that psychic stimuli produce an allergie state or replace antigen when a reaction is precipitated The exact causal relationships are not definitely known. It may be assumed that psychic trauma modifies the irritability of the autonomic nervous system so that stimuli of subthreshold level become full excitants.

The literature, however is meager in actual records of cases with manifestations of psychosomatic origin the reasons being the rarity of their occurrence or our inclination to discount such symptoms in a patient with a nervous background. Such cases have been described by McAuliffe and his associates, by Hall, and Karnosh.

The following cases support the thesis of a psychic origin of symptoms also seen in allergy and, therefore differentiated from it. They may be more frequent than we now believe They are presented here because of their rarity and, also because one appeared to present typical hay fever and the other bronchial asthma while under observation. Both gave negative akin reactions to inhalants, foods, and molds. There was no evidence of infection in the upper respiratory tract in either patient. Both recovered and have remained well after the precipi tating causes were eliminated.

Case Reports

A H was 20 years old when she developed symptoms thought to be seasonal hav fever There was a family history of allergy. She was a premedical student and had a heavy school program in the summer of 1944 in order to enter medical school in the fall of that year. She was tense and anxious to do well Attacks of speezing occurred during all the summer and ceased completely late in September when her B.A. degree was granted. During the following winter she felt perfectly well.

In the spring of 1945 she was admitted to medical * Presented before a meeting of the American Acad my of Allargy Hotel Pennsylvania, New York City Nov 2" 1946. school. At this time she was impressed by reports of difficult work ahead of her She began to worry sneeze and develop marked nasal obstruction Skin tests were negative to all inhalants foods and molds Ophthalmic tests with all pollens were negative Since her suffering was marked she went to Atlantic City and then to the White Mountains, but received no physical benefit. In October she entered medical school The work was enjoyable and she soon realized that she was as good or better than her average classmate The nasal symptoms subsided completely She complained only of occasional abdominal cramps before examinations. Her work at school that year was excellent In the summers of 1946 and 1947 there was no return of any hav fever symptoms.

Mrs H K. was 39 years old She also had a family history of allergy She was married at the age of 14 was twice divorced, and four years ago married a man 16 years her sonior with whom she quarreled daily Asthma attacks began at the age Skin tests were all negative On physical ex amination there were sonorous and sibilant rales throughout both lungs. She was treated with an autogenous sputum vaccune but made little improvement. After a year of observation are disappeared Eight months later she returned saying she had been perfectly well since the last treatment given a few days before her husband died

Comment

Our present concept of allergy demands an antigen-antibody reaction. Since the factors that mediated the symptoms in these two cases do not fall into this category they were not termed psychosomatic hay fever and asthma The meager knowl edge at our disposal at present does not warrant the assumption that an antigen-antibody reaction took place in those cases. They are presented, therefore as psychosomatic rhinorrhea and dyspnea.

Summery

- Cases of psychosomatic rhinorrhea and dyspnoen, showing histories and physical examinations of seasonal hay fever and asthma are reported
- 2 There were no positive evidences of allergy in either case and skin reactions were negative.
- 3. The precipitating cause in both cases appeared to be psychic stress and strain.
- 4 Both patients were relieved completely when the stress and strain were eliminated.

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AMELIORATION OF PEPTIC ULCER SYMPTOMS FOLLOWING SPLANCHNICECTOMY

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(From the Department of Neurological Surgery, Jewish Hospital of Brooklyn)

THAT the genesis of peptic ulcer may be related to disturbance of the autonomic nervous system Wolf and Wolff has been suggested frequently showed that the emotions of anxiety, resentment, and fear caused varying degrees of altered gastric motility, vascularity, and hydrochloric acid secretion 1 Findings such as these constitute part of the evidence in support of the hypothesis that, regardless of what may be the successive links in the chain of events leading up to formation of an ulcer, the initial insult, predisposing to subsequent ulcer formation, is a local impairment in the vascular supply of the gastric or duodenal mucosa steen believes that acid-peptic digestion of the mucosa is the important cause of ulcer, and also that factors impairing mucosal blood flow for even short periods of time probably augment the ulcer diathesis 2 He suggests that in certain instances arteriosclerosis of the gastric arteries may be of some importance in predisposing to ulcer

An opportunity to test this hypothesis arose in the case of a patient who had had symptoms of peptic ulcer for fifteen years prior to operation and who underwent splanchnicectomy for hypertension The patient has been restudied recently, not quite five years following operation, to ascertain the effect of surgical interruption of the splanchnic vasoconstrictors, not only on his blood pressure, but also on his former gastric symptoms

Case Report

The patient was operated upon at the age of thirty-seven on May 20, 1942, at which time a bilateral supradiaphragmatic splanchnicectomy was carried out for essential hypertension known to have been present for about two years His most disabling preoperative symptom had been headache Preoperatively, his diastolic blood pressure was generally in the vicinity of 120 mm H pressure ranged between 160 and 220 mm His systolic

An interesting feature of the patient's history was the fact that for fifteen years he had been subject

to "heartburn." Customarily, he would experience epigastric pain which was relievable by eating To help relieve his discomfort he would take as many as 15 syntrogel tablets daily A gastrointestinal series revealed hypermotility and spasm of the duodenal It was presumed that he had an ulcer

The most recent follow-up on the patient was on February 24, 1947, four years and nine months This examination disclosed following operation that although the patient was actively at work and his former distressing headaches had not recurred, his hypertension had returned The diastolic pressure ranged between 90 and 110 mm and the systolic between 150 and 170 mm

Questioned about his gastric symptoms, the patient stated that although these had been present right up to the time of operation, they cleared up gradually and completely in a few months time and have never since recurred Alkali medication was

never resumed

This report is hardly sufficient to permit any assumptions regarding the pathogenesis of peptic ulcer, but it lends support to the general concept that this condition represents a disturbance of the autonomic nervous system, and more specifically, of one of its neurovascular components

It indicates the need for the accumulation of further data, particularly among large series of cases of hypertension, treated by splanchnicectomy, where peptic ulcer may coexist. If such investigations tend to confirm the findings in this report, then it may be more reasonable to think of peptic ulcer as being not unlike other neurovascular disorders, such as Raynaud's Disease, involving imbalance of other parts of the autonomic nervous system

189-02 64TH AVENUE

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NEW YORK STATE'S BIRTH RATE CONTINUES DECLINE

New York State's birth rate in November continued the decline that started last September, H E Hilleboe, State Health Commissioner, has reported Nevertheless, the number of births for the first eleven months of 1947 reached a record total of 300,000

The birth rate in November was 21 2 per 1,000 population, with 21 9 in October, and 21 8 in Sep-

All these figures are below those of the corresponding months of 1946 November's rate, however, was a 26-year record for that month, with the exception of 1946

The State's death rate for November was 11 per 1,000, compared with 10 7 in November, 1946. The increase was attributed to a greater mortality. from heart disease and cerebral hemorrhage

Among the causes of death, new low records were established by tuberculosis, with 35 9 per 100,000 population, appendicitis, 3 3, and nephritis, with 39 3 The influenza death rate, 0 8, was equally low only once

DIAPHRAGMATIC (ESOPHAGEAL HIATUS) HERNIA

LEONARD K. STALKER, M.D. M.S., and Morris J. Moskowitz. M.D., Rochester, New York

(From the Department of Surgery Highland Hospital)

THE fact that a diaphragmatic hernis is frequently wrongly diagnosed is well demonstrated by a case recently treated by us. This patient was diagnosed at various times as having gallbladder disease, peptic ulcer and finally carcinoma but actually was proved to have an esophageal hiatus bernia. Our diagnosis was made by roentgenographic examina tuon, following an episode of hematemesis. This was confirmed by operation

Case Report

A white woman, age 66 years, was admitted to the orthopedic service on January 13 1947 She had an impacted fracture of the right wrist. She was seen in consultation shortly after admission because of an acute attack of indigestion This was associated with nausca, vomiting, and epigastrio pain She had had recurring attacks of indigestion ever since an attack of typhoid fover in 1900 On numerous occasions herm digestion had been diagnosed and treated as being due to guillibidder disease. She



F10 1 Preoperative film showing esophageal histus hernia.



Fig 2 Postoperative film showing stomach in normal position

stated that a number of gallstones had been passed by rectum.

On other occasions she had been treated for a peptic ulcer During the past year she had lost 40 pounds in weight had become dyspincic and had developed an anemia. On a number of recent occasions she had vomitted coffee ground material. These facts had led to the probable diagnosis of carcinoma of the stomach. In 1920 a subtotal abdominal hysterectomy and bilateral salpingo-opphorectomy had been performed

Examination rovealed a woman who was chronically Ill She had lost weight and appeared anomic. The physical findings were not significant. Choleoystography showed a normally functioning gall bladder without stones. A roentgenogram of the chest showed a large gas bubble behind the least. The patient was then given barium by mouth and at least two thirds of the stomach was found above the diaphragm (Fig. 1) The diagnosis was diaphragmatic hernis.

The patient continued to vomit rather large amounts of blood, and on February 6 1947, the left pluronic narve was resected. The patient's symptoms decreased but did not disappear. A roentgenogram taken at this time showed paralysis of the left portion of the diaphragm and the continued presence of the herniated stomach.

presence of the herniated stomach.

On February 25 1047 under intratracheal anesthesia a transabdominal repair of the hernia was accomplished. An esophageal histus hernia with an opening approximately 10 cm. in diameter was found the herniated portion of the stomach was adherent

The adhesions were freed, the stomach was returned to the abdominal cavity, and a splenectomy was performed to facilitate exposure

The patient made an uneventful recovery was out of bed on the fourth postoperative day and was dismissed from our service on the tenth post-

operative day

She has been asymptomatic since the operation, and recent roentgenograms revealed a satisfactory repair with the stomach in normal position and without evidence of organic disease (Fig. 2)

Comment

This case illustrates that what seems to be an obvious diagnosis should not be accepted without sufficient proof

It is possible that this patient had a diaphragmatic hernia which was progressively enlarg-

ing for more than forty years. The onset of her indigestion had occurred forty-seven years previously during an attack of typhoid fever sequent sequence of events made the suspicion of peptic ulcer and, later, carcinoma reasonable diaphragmatic hernia had been considered, it might have been diagnosed earlier. It is well illustrated that in a case such as this, complete roentgenographic The true state of affairs in studies are necessary this case was first suspected when roentgenograms of the chest showed a large gas bubble behind the heart

Summary

A brief discussion of esophageal hiatus hernia has been presented. A case has been reported which illustrates many of the problems associated with its diagnosis and treatment

REPORT OF THE COMMITTEE ON MATERNAL WELFARE OF THE MONROE COUNTY MEDICAL SOCIETY

The Committee on Maternal Welfare, in its three meetings during the year, continued the analysis of maternal deaths Because of fewer cases to be discussed, the number of conferences necessary was much lower than in the first few years of the study There were 20 to 28 deaths as against 6 to 10 now in the face of 10,000 as against 6,000 births, a much higher birth rate

Deaths from hemorrhage, particularly the post-partum variety, are causing the chief anxiety This is due to two factors first, because of the marked decrease in sepsis and tovemia as causes of fatalities, deaths from hemorrhage, the third principal cause, are stressed more because hemorrhage has not decreased in the same ratio, and second, because on close scrutiny it is found that many of these deaths might be prevented were there an appreciation of the gravity of hemorrhage Treatment is too often "too gravity of hemorrhage Treatment is too often "too little and too late" This observation has also been made by other committees throughout the country, and routine blood typing on all parturients, together

with facilities for rapid transfusion, are being urged Many of our cases are not true obstetric deaths but every year we investigate deaths from medical causes like cardiac and pulmonary conditions that fall to our lot because they occur in pregnant women

The decline in maternal mortality during the past fifteen years has been truly remarkable at all levels county, state, and nation, and the rate for Monroe County is among the lowest

Reduction per 10,000 births can be summarized as follows

1933 1946 United States 63 21 New York State 51 12 6 Monroe County 45

From present indications it would look as though the 1947 death rate would reach an all-time low, for as of December 1 there were 10,500 births and 4

deaths or 3 8 per 10,000 At the last meeting it was voted to conduct a second ten-year study of cesarean section on a city-wide basis, to supplement the survey of 1926 to 1936 done by this committee Interest in the analysis committee has grown, as evidenced by the attendance and the discussions James K Quigley, MD, Chairman -The Bulletin, Rochester, New York, December, 1947

HAY FEVER HAVENS FOUND IN 14 UPSTATE LOCALITIES

There are fourteen localities upstate where hay fever sufferers can expect relief, the State Health Department has announced

In a 1947 survey, nine of the fourteen produced ragweed-pollen indices low enough to classify them as "practically free" areas The remaining five are rated as "moderately free"

Heading the "practically free" list is Windham, Greene County, with an index of zero Based on the survey figures, the department said, it is "the most desirable hay fever haven in the state"

Next in line are three Adirondack Mountain com-

munities—Keene Valley, Long Lake and Mc-Keever—each with an index of one Other "free areas" and their ragweed-pollen indices are, according to the Health Department

Speculator, 2, Tannersville, 4, Schroon Lake, 4, Wanakena, 4, Big Moose, 5, Indian Lake, 6, Pine Hill, 6, Tupper Laker, 7, Woodstock, 9, and The Hague, 14

A locality with an index of five or less is considered by the Health Department to be a "practically free" area, one with an index of between five and fifteen, a "moderately free" area

CONFERENCES ON THERAPY

DEPARTMENTS OF PHARMACOLOGY AND MEDICINE, CORNELL UNIVERSITY MEDICAL COLLEGE
AND THE NEW YORK HOSPITAL

THESE are stenographic reports of conferences by the members of the Department of Pharmacology and of Medicine of Cornell University Medical College and New York. Hospital, with collaboration of other departments and institutions. The questions and discussions involve participation by members of the staff of the college and hospital, students and visitors. A solected group of these conferences is published in an annual volume. Cornell Conferences on Therapy, by the Macmillan Company

Therapeutic Uses of BAL

DR. McKeen Cattell BAL, or British antilewisite is one of the most important developments in the field of drug therapy which occurred as a result of the war. It has importance both from a practical and a theoretical standpoint. I believe it is one of the very few instances of a drug which, developed according to pharmacologist's specifications, has actually been found to work.

Today, we propose to review the work of the pharmacologus and the climican in relation to the thempeutic use of BAL. Dr. Chenoweth will start off with a brief account of the pharmacologic aspects.

Dr. MATMARD B CHENOWETH BAL has already achieved the status of Council acceptance. The Council on Pharmacy and Chemistry of the American Medical Association has applied a new name dimercaprol, which is a contraction of its chemical name, 2,3-dimercaptopropanol Those who worked with it under the name of BAL, however, are likely to continue to call it that.

It is an oily, coloriess liquid poorly soluble and instable in water It has a strong, garlicky odor. It is a dithiol derivative of glycerol, one of many dithiols synthesized and screened in recent years, and the one which offered the most promise for practical application in the treatment of arsenic poisoning

The search for a compound like BAL was based on the concept of the mechanism of poison ing by arsenic and other heavy metals. It has long been known that trivalent arsenic, in the case of the spirochete and human tissue as well blocks metabolism by combining with the —SH-groups of entryme systems. The idea, therefore, was to provide a source of —SH-groups which could compete with the tissue —SH-groups for the arsenic Early experiments with monothiols, such as cysteine and glustinone indicated that some such action could develop but with these substances it was of a magnitude insufficient to produce a clinically useful effect. The search was extended to other sources of —SH-groups, the

dithiols. BAL was one of the first of these to be examined and was found to possess the necessary proporties. It has been demonstrated that a competition for arsenic develops in the body between —SH-groups of tissue ensyme systems and the -SH-groups of BAL It has further been shown that these reactions are reversible, and the direction of the reaction is influenced by the presence of available -SH-groups from the one source or the other The effectiveness of a dithiol appears to be directly related to its ability to form a relatively stable heterocyclic ring containing the arsenic Thus tissue -SH-groups already in combination with arsenic can be made to release the metal when large enough doses of BAL are given, and the toxic action on cells may be counteracted, even though some time has elapsed This indicates that BAL would be chnically useful even after symptoms of amenic poisoning have developed It also indicates that treatment with BAL must be prolonged until the arsenic is climinated, so as to maintain a prepon derance of -SH-groups derived from BAL. It should be remembered that, although the chemi cal reaction of the tissue thiol radicals and ar senic is reversible, some of the effects of poisoning may be irreversible. BAL cannot therefore always be expected to relieve all of the effects of arsenic poisoning This fact becomes increasingly important with the lapse of time after ar senic poisoning before the BAL treatment is started As a consequence of the liberation of arsenic from its combination with -SH-groups of the tissue ensyme systems and the formation of BAL-bound arsenic, the arsenic level in the blood. and the amount excreted in the urine increases. Thus, not only are cells saved from poisoning by the arsenic in the body but the poison is also eliminated from the body. This, then, is the basis for the use of BAL in the treatment of heavy metal poisoning

This is not, however, the entire story BAL produces disagreeable and toxic effects In experimental animals BAL produces a character

3.5

istic train of symptoms, small doses cause blinking, blepharospasm, lacrimation, salivation, and conjunctival edema, larger doses, ataxia, urination, and respiratory stimulation, fatal doses, respiratory depression, pulmonary edema, and convulsions. In addition, there are some interesting effects on the cardiovascular system. There is a primary action on certain peripheral artenoles, a reversible constriction, which, after small doses, produces a rise in blood pressure, and after larger doses, produces enough capillary damage to cause a fall in blood pressure and signs of pempheral vascular failure The rise in pempheral resistance is marked in the limb vessels but is not present in the arterioles of the liver or the splanchnic area BAL also causes a rise of blood lactic acid and a lowering of blood pH and carbon dioxide combining power These effects are produced by intravenous and intramuscular injection, and, since the agent is absorbed from the surface of the skin, they are seen after cutaneous application when the dose and the area over which it is spread are large enough.

BAL is rapidly eliminated by the experimental animal, and the effects of a nearly fatal dose may disappear in five or six hours Toxic effects have been observed in humans who have received therapeutic doses of BAL, namely, paresthesias, sweating, a sense of warmth, pain (in limbs, jaws, abdomen, and head), lacrimation, blepharospasm, salivation, vomiting, unrest, apprehension, weakness, fatigue, acceleration of the heart, and a rise of both systolic and diastolic blood pres-No serious consequences have been re-These effects are usually produced by ported single doses greater than 3 mg per Kg as large as 8 mg per Kg produce rather marked The effects come on quickly after intramuscular injection, in a matter of a few minutes in some cases, but last only an hour or Doses of 5 mg per Kg have been given at intervals of three hours during the day without significant cumulation, although individual doses have produced symptoms The usual dose prescribed for therapeutic effects is 25 to 3 mg. this rarely produces significant discomforts is generally given at four-hour intervals to avoid the danger of cumulation

BAL is provided for therapeutic use in ampules of 4.5 cc, consisting of a 10 per cent solution of BAL in peanut oil, together with 20 per cent benzyl benzoate which is used as a solubilizer. It is injected intramuscularly and often causes some pain at the site of injection. An ointment of BAL in petrolatum was developed during the war for local use after exposure to arsenical blister gases. This is no longer available, since the possibility of this type of exposure to arsenic is no longer a problem. However, it can

be made up for local use in cases in which there is a reaction due to the local effect of arsenic. In this connection it is well to remember that BAL may be absorbed from the surface of the skin, perhaps even more effectively through a denuded area such as may be present after local action of a metal.

All of the spade work on animals and humans was carried out with arsenic Interest then turned to the possibility that the therapeutic action of BAL might also apply in case of poisoning by other heavy metals. Investigation, both in the laboratory and in the clinic, has already indicated that the value of BAL does extend to poisoning by other metals Clinical experience exists, which shows that BAL is effective in the case of poisoning by gold and mercury experimental evidence of its value in the case of poisoning by antimony, bismuth, chromium, and nickel, but clinical support is still lacking different results have been obtained in treatment of experimental poisoning by thallium and silver, while in the case of poisoning by lead and selenrum, matters seem to be made worse by BAL

DR. CATTELL Dr Chenoweth, is it not true that the toxic symptoms of BAL, which have been reported in humans, are fairly evanescent?

DR CHENOWETH Yes, quite fleeting, a matter of an hour or so

Dr. CATTELL We are not alarmed by touc symptoms in humans, because, in experimental testing with larger doses of the compound than are used clinically, all symptoms subsided within a very short time

Perhaps we should leave further discussion until after we hear what Dr Riker has to say about the clinical aspects of BAL

DR WALTER F RIKER, JR. Chinically, BAL has been studied most intensively in the treatment of arsenic poisoning, especially in the treatment of reactions arising from antiluctic therapy

As already indicated, BAL is available as a 10 per cent solution in peanut oil, solubilized with benzyl benzoate This solution is dispensed in ampules containing 4 5 cc for intramuscular in-The symptoms which BAL may produce in humans have already been indicated Their occurrence depends largely on the size of the dose and the frequency with which it is given. In a series of studies on normal men, it was found that a dose of approximately 3 mg per Kg can be given before to ac symptoms appear been mentioned, the reactions which occur from these and even larger doses are of minor importance, since they are reversible and of short dur-There have been no serious reactions complicating BAL therapy in man. With a dose of 25 mg per Kg the incidence of reactions after approximately seven hundred injections was less

than 1 per cent, and these were of a minor character, consisting mainly of mucceal irritation BAL is fairly rapidly eliminated so that the danger of cumulation is small A study of a series of patients by Modell, Gold, and Cattell demon strated that relatively large doses 5 mg per Kg, given at three-hour intervals for four doses, did not produce any cumulative effect.

The BAL regimen in the treatment of arsenic poisoning is based largely on the toricity studies Thus, an intramuscular dose of 2.5 mg ın man per Kg of BAL may be chosen for a mild case of poisoning, and four to six such doses may be ad ministered every four hours for the first two days. The same dose may be repeated once or twice daily from the third to the tenth day courses of BAL will vary with the individual case. but there is rarely need to administer the doses more frequently than every four hours severe case of poisoning, it may be desirable to increase the dose to 3 or 4 mg per Kg. despite the appearance of toxic symptoms from the BAL. In the first two days, this dose may be repeated every four hours until six such doses have been given, and thereafter it is administered once or twice daily until the tenth day, or until treatment is no longer required There is still insufficient clinical experience to decide the precise dose or duration of treatment in any particular case

The member clinics of the Cooperative Clinical Group have used BAL in the treatment of complications arming from arsenotherapy sults obtained were correlated and evaluated by Dra. Harry Eagle and Harold J Magnuson of the United States Public Health Service and the Johns Hopkins University The results in 55 cases of arsenical encephalopathy caused by in tensive manharsen therapy have been reported Of these, 15 were considered mild cases, without come or convulsions. In this group treatment was begun within twelve hours after the onset of symptoms All 15 recovered completely by the fourth day, making the average 25 days total of 31 of the 55 cases were classified as severe because of convulsions and come and were treated within an hour of the onset of symptoms. Among these, there were 24 complete recoveries and 7 deaths.

The average total dose of BAL used in these cases was somewhat larger than in the previous group, and the time to complete recovery was an average of four days. The remain ang 0 cases were also of the severe type, but in these, treatment was delayed for thirty hours or longer after the onset of the symptoms. The results here were much less impressive, 5 of the 9 died, but I think that without BAL treatment, the outcome is apt to be fatal in nearly all cases of arsenical encephalopathy in which coma, con vulsions, and high fover are present.

There were 88 cases of arsenical dermatitus treated with BAL. Among these, 37 were of a Treatment was begun in an average mild form of about ten days after the appearance of the rash, improvement was in evidence in an average of about two days, and in about five days, recovery was complete Only 3 of the patients in this group failed to show any response to treatment. There were 51 cases of the severe form of dermatitus, the classical exfoliative type. In these, treatment was started in an average of about exteen days after the onset of symptoms. In this group, 41 showed distinct improvement in an average of about three days, and complete recovery in thirteen days. The response to treatment was prompt, within twenty four hours there was a fall in the temperature and the in flammatory reaction and edema of the skin began to subside

Experience with jaundice associated with arsenical therapy has not yet provided a definite answer as to the value of BAL. In a group of 16 reported cases, there were only 5 in whom BAL appeared to provide symptomatic relief. The clinical recovery in these 5 seemed to be unusually rapid We had a patient in this hospital who developed mundice following argenical therapy There was the question as to whether the jaun dice was due to the argenical treatment or to a coincidental infectious hepatitis. We decided to try BAL, and the results strongly suggested that it was beneficial, the icteric index declined from 95 to the normal level after treatment for four days and the patient was discharged from the hospital, symptom-free, after seven days follow up in this patient showed no signs of recurrence of jaundice or of liver disease course in our patient was similar to that in the 5 cases reported by Eagle and Magnuson to which I have just referred The remainder of their 16 cases showed no clinical improvement on BAL therapy It may well be that the arsenic is not the sole factor in the production of this type of jaundice, for if it were, the use of BAL should bring rapid recovery because of the established interaction of BAL and arsenic. BAL has been used in the treatment of blood dyscrasias resulting from arsenotherapy, but the experience is still too limited for a satisfactory evaluation. It appears to have been successful in granulocytopenia and agranulocytosis resulting from arsenic but apparently was unsuccessful in the arsenical aplastic anemia

In the treatment of poisoning by arsenic in man, the scorer BAL is given the better is the response. There is fairly strong indication that the therapeutic response to BAL is related to the withdrawal of arsenic from the tissues. The detection of increased exerction of arsenic in the turne is another matter. Such an increase is

frequently observed, and the peak excretion occurs approximately four hours after the dose of BAL. It is not always possible, however, to demonstrate an increase in the urmary excretion of arsenic, sometimes as the result of the fact that the amounts due to BAL are too small to be detected in a twenty-four-hour total excretion

BAL has proved very effective in the management of acute poisoning by bichloride of mer-The group working with Dr Longcope of the Johns Hopkins Hospital, Baltimore, in an early report, presented an account of 42 cases of bichloride of mercury poisoning with doses varying from 0 5 to 20 Gm Among these, 37 made complete recoveries, treatment with BAL having been instituted within four hours after the dose Many of these patients were was swallowed exceedingly ill when treatment was started Symptoms were relieved dramatically compared a group of 86 patients with bichloride of mercury poisoning in whom various measures other than BAL were used with a group of 24 cases in which the BAL treatment was used both groups the dose of bichloride of mercury was 1 Gm, and treatment was started within the first four hours Among those treated with BAL there were no fatalities, whereas in the control group 31 per cent succumbed

DR CATTELL The subject is now open for general discussion Are there any questions?

DR HARRY GOLD I should like to ask Dr Riker how he would explain the fact that BAL is so effective against arsenical poisoning, and yet, in some patients no increase in the excretion of arsenic in the urine is detected. He stated that the increased excretion may be small and may occur in the form of a brief peak of excretion and, therefore, escape detection in a twenty-four-hour specimen of urine. Is it likely that such a small increase in the excretion of arsenic could be responsible for the dramatic effects of BAL in controlling the situation in a case of arsenic poisoning?

DR RIKER We are not certain of the explanation. It may be that this small increase in arsenic excretion is highly significant, because it is arsenic released from combination with a vital organ or tissue. There are other possibilities. There is indication that BAL alters the distribution of arsenic between the urine and the feces and an examination of the urine alone may fail to reveal the increased excretion of arsenic. There is also the possibility that the arsenic removed from vital tissues and combined with BAL may circulate in an inactive form, so that, even though excretion is not accelerated, the combination is doing the patient no harm

DR CHENOWETH I should like to point out that the doses of BAL used in the studies of Dr Longcope and his group were as high as 7 mg per Kg in cases of acute poisoning by bichloride of mercury. In spite of these large doses, they observed no toxic symptoms from BAL. This may be due to the fact that the large quantities of mercury, present in these cases, combined with BAL and thereby prevented toxic symptoms

DR CATTELL The mutual antagonism between BAL and metals is seen also in the case of arsenic Not only is BAL an antidote to arsenic, but it has been shown under experimental conditions of arsenic poisoning that arsenic is an antidote to BAL. In the presence of arsenic, animals are able to tolerate larger doses of BAL without showing toxic symptoms of the latter

In connection with the problem of therapeutic doses of BAL, it may be well to emphasize experience in luetic patients who are not poisoned with arsenicals. In these patients, intramuscular doses of 5 mg of BAL per Kg every four hours and single doses as high as 8 mg per Kg were given without serious effects. It is true that there were many disagreeable symptoms with such doses, but there were no effects which gave cause for alarm.

Visitor Does BAL have any value in poisoning by gold?

DR RIKER In vitro experiments show that gold reacts with BAL to form a thio-aurate There is no experimental work in animals, as far as I know, which shows that BAL is effective in poisoning by gold preparations. There are, however, some recent clinical results suggesting a favorable effect of BAL in toxic reactions produced by chrysotherapy in arthritis.

VISITOR Which of the complications of chrysotherapy have been successfully treated by the use of BAL?

DR RIKER Dermatitis, both the exfoliative and seborrheic types, conjunctivitis, ulcers of the palate, thrombopenic purpura, and granulopenia have been reported as helped by BAL, but more experience is necessary for the final evaluations of BAL in this type of metal poisoning

VISITOR Could one confuse the reactions from BAL with those of the metal poisoning?

DR RIKER In general, the presence of metals, such as arsenic, mercury, or even gold, appears, as already indicated by Dr Cattell, to reduce the toxicity of BAL, and with the doses generally given in treatment, severe reactions from BAL are not to be anticipated. I cannot think of symptoms due to BAL which may be confused with those due to one of the heavy metals. The picture produced by BAL is unique.

STUDENT IS BAL useful in lead poisoning?
DR CHENOWETH BAL may move the lead around in the body, but no beneficial end is achieved

STUDENT How about cadmium posoning? Dr. CATTELL The animal experiments on the use of BAL against cadmium show that this is a special case BAL seems to control the acute symptoms of cadmium poisoning, but the BAL-cadmium compound is itself toxic to the kidneys, and the animals subsequently die of renal failure BAL, therefore, is not very promising as an anti-dote to cadmium poisoning.

There are a good many compounds related to BAL which have been studied. One of them is the BAL glucoside complex which seems to offer special advantages. It has not yet been used clinically. Dr. Phillips worked with it experimentally. I wonder if he would comment?

DE FREDERICK S PHILLIPS The molecule of BAL glucoside is composed of a glucose moiety in glucosidic linkage with the oxygen of 23dimercaptopropanol The hydrophilic properties of the glucose mosety probably account for the high aqueous solubility of BAL glucoside, a property not shared in the same degree by BAL itself which is a hpid-soluble substance. In fact BAL glucoside was created in the hope of obtaining a compound which would exhibit the antidotal properties of BAL but which would also be sufficiently water soluble to be administered in travenously It was also hoped that the BAL glucoside might remain for the most part in the extracellular spaces and, therefore, be less toxic than BAL. Indeed, studies of the pharmacology of BAL glucoside have shown that it is less toxic than BAL and that it could probably be admin istered safely in doses 10 times those recommended for BAL. Moreover, to ue actions following fatal doses of the glucoside appear to differ from those caused by toxic does of BAL. The acute stimulation of the central nervous system and the capillary damage caused by BAL are not ob-Toxic actions which have been observed following administration of various preparations of BAL glucoside, may be due to chemical impurities. The chemical impurities, present in preparations of BAL glucoside, constitute the major disadvantage of the agent as it is now avail The compound has never been sufficiently purified to be useful clinically Impurities render it unstable so that it is difficult to preserve preparations of known activity. In addition to its instability BAL glucoside is difficult to prepare and is, therefore, costly However, if the glucoside can be prepared in a relatively pure state it may well prove to be a therapeutic superior to BAL. In the case of experimental cadmium poisoning in which BAL is of no value, BAL glucoside appears to be quite effective. Its effi cacy in cadmium poisoning probably results from the formation with cadmium of a soluble complex of low dissociability which remains extracellular

and is excreted without appreciable reabsorption by the renal tubule. On the other hand, the treatment of cadmium poisoning with BAL enhances the nephrotoxic actions of the heavy metal and thereby fails to reduce cadmium toxicity in experimental animals. In view of the results obtained in experimental cadmium poisoning, it is possible that other types of metal poisoning which fail to respond successfully to BAL therapy may conceivably be favorably influenced by compounds like BAL glucoside. It is to be hoped therefore, that it will soon be possible to obtain relatively pure BAL glucoside at a cost which is not prohibitive.

DR CATTELL Dr Kensler, you worked with these compounds Have you anything to add? DR. CHARLES J KENSLER I would like to make an addition to the arsenic story one form of arsenic poisoning namely, by arsine, AsH. in which judging from our experimental results I think, BAL is of little value and may even prove harmful. For example, the LD to dose of BAL in the normal rabbit is about 100 mg per in rabbits which have been poisoned with arsine, the LD to dose drops to from 25 to 30 mg ner Kg This is in marked contrast to the sit untion in levisite poisoning in which case several lethal doses of lewisite (CHClCHAsCl.) and BAL will neutralize each other During the course of our investigations at Memorial Hospital we found a closely related compound which was effective for the treatment of arome poisoning That compound is the ethyl ether of BAL. It is effective as a therapeutic agent in the dog mon key, and rabbit when applied to the skin as a pure compound or when injected intramineularly It has been applied to the skin in man without any observable toxic effect in doses comparable to those which save the lives of dogs and monkeys poisoned with arone It has never had any trial in man because no opportunity has arisen for its

Dr. CATTELL Dr Riker, Dr Chenoweth, and others of us have studied the pharmacology of this compound. The ethyl ether of BAL, which is less soluble in water but more soluble in oil, has a selective action on the central nervous system in ests and definite damage to the central nervous system was demonstrated in these animals. It was this fact that caused some apprehension about its use in man, although in dogs monkeys and all the other animals which were studied no such effect was produced

In connection with the therapeutic effects of BAL in arsenic poisoning which you described Dr Riker do you attribute the whole effect to the increased elimination of arrene from the body?

DR. RIKER No, I don't think so I believe that the chief mechanism is the combination of arsenic with the sulfhydryl groups of the BAL in consequence of which the arsenic becomes converted into a relatively innocuous form of the arsenic which is exposed to the BAL may be free and not yet combined with tissue, while some of it is metal removed from combination with tissue sulfhydryl groups which has already taken place The BAL and arsenic form a thio arsenite This compound has a low hydrolysis constant and cannot be readily dissociated Some of it may be fairly rapidly excreted, while the rest may be stored in the organism as a relatively innocuous complex Either case results in protecting the body tissues against arsenic There is evidence that in the animal the insoluble complex circulates in a very small particulate form, possibly of a colloidal nature, and that it may be stored in the reticuloendothelial system There are cases of dermatitis resulting from a minute amount of arsenic, and it is believed that this may represent a hypersensitivity reaction BAL has proved effective in this type of condition, a fact which suggests that the binding of a minute amount of arsenic with BAL is, in effect, equivalent to neutralizing an antigen

DR CATTELL I think this aspect of the action of BAL is an important one, at least in the experimental animal, because, although the animal may be saved, the amount of arsenic excreted may represent a very small fraction of the dose of the metal which was given

Dr Riker, would you tell us of the interesting experiments which you carried out with Dr Rosenfeld showing the shift of arsenic from the cells

DR RIKER We found that the arsenic content of the blood plasma increased after BAL was administered to an animal poisoned with arsenic, and that this was associated with a release of arsenic by the cells

DR CATTELL It disappears from the red blood cells and apparently accumulates in certain tissues, particularly in the reticuloendothehal system, suggesting that there may be storage there

DR CHENOWETH In connection with the use of BAL for the treatment of toxic effects of the arsenicals in the therapy of syphilis, it might be well to mention that the BAL not only protects the patient's tissues against the arsenic but also protects the spirochete against the arsenic. The result is that the antisyphilitic therapy is no longer effective if BAL is used at the same time

DR KENSLER Does BAL block the action of the mercurial diuretics?

DR CATTELL There are now several studies which show that BAL reduces the toxicity of the mercurial diuretics

VISITOR One paper, as I recall, referred to this

antagonism in the case of the cardiotoxic effects of the mercurial diuretics. Is there any information as to the effect of BAL on the diuresis produced by the mercurials?

DR CATTELL There is evidence that it does that too If the BAL-mercurial complex produced diuresis, it might be a great advantage, but unfortunately, that does not seem to be the case

DR RIKER On the basis of our information, one would expect BAL to antagonize all actions of the mercurial diuretic. I would expect it to check the diuretic effect of the mercurials by preventing the interaction of the mercury with the protein of renal tubules.

MR DONALD A CLARKE There is unpublished work indicating that BAL not only inhibits the diuresis of the mercurial but, in addition, has an antidiuretic action of its own

DR CATTELL The effect of BAL on the excretion of metals seems to me one of the most impressive aspects of the action of this compound Perhaps Dr Riker would describe the typical course of arsenic excretion after a dose of BAL

DR RIKER After a single test dose of BAL in a case of arsenic poisoning, there is usually a sharp rise in the urmary excretion of arsenic in the next twenty-four-hour specimen This is followed by a rapid return to the control level Such was the case, for example, in the patient with arsenical aundice to which I have already referred fore the BAL was started, the concentration of arsenic in the urine was rather low, considering the amount of arsenic that had been given administration of several doses of BAL in this case produced a very sharp increase in the urinary arsenic, on the following day, the concentration was about 4 times that of the control, but on the next day following, the concentration had returned to the control level in spite of the fact that the administration of BAL was continued high icteric index and the symptoms of poisoning showed a rapid reversal A point of importance here is the possibility that the BAL may continue to exert a beneficial effect even during the period when the level of arsenic excretion in the urine is not substantially elevated It would seem reasonable, therefore, to continue the use of BAL in the presence of clinical evidence of arsenical poisoning even when the arsenic excretion level in the urine is not elevated One should bear in mind that the complete healing of arsenical lesions, even after the arsenic is removed, may take a fairly long time

The decision as to how long the BAL therapy should be continued will require a great deal more clinical experience. The difficulty of determining how long BAL treatment should be continued is well illustrated by the problem of arsenical hepatitis. There has been some debate among

syphilologists concerning the exact nature of the inundice complicating arsemotherapy. There is reason for believing that if it responds promptly to BAL therapy, the jaundice is clearly due to the arsenic directly, although there still remains the possibility that a delay in response, or even a fail ure in response, may be due to the persistence of a liver damage produced by arsenic or by some complicating factor

STUDENT Is BAL equally effective against arsenic taken in a variety of forms such as Paris

green and rat poisons?

DR CATTELL It is, in experimental animals. The one known exception, arsine, which Dr Kensler mentioned, is of no practical importance at present.

Dr. Riker It is effective against Fowler's solution, which is an inorganic arsenic prepar-Dr Walsh McDermott and I treated a very severe dermatitis resulting from Fowler's solution The dermatitis was similar to a bul lous pemphigus with large bullae over the entire body The patient was seriously ill at the time of admission as the result of secondary infection and fluid loss from the rupture of the bullae. Previous nonspecific therapy had been of no avail The history revealed that the patient had been given Fowler's solution for a minor skin conditon a number of years before and that he continued the medication on his own by drinking from the bottle daily without concern. We started BAL therapy, and the response was dramatic. Prior to BAL, there was a very low level of arsenic excretion, whereas following it there was a tremen dous outpouring of arsenic in the urine and the lemons started to clear Sulfadiazine therapy was instituted to control the secondary infection. The patient was well in about three weeks except for peripheral neurities which cleared up a few months after discharge Other cases of possoning by Fowler's solution which responded well to BAL therapy have been reported

Summary

Dr. Gold We may now summarise the essential points covered in the conference. The history of specific antidotes to poisoning by metals is substantially an account of unfulfilled promises. Sodium throsulfate was introduced in 1920 as an antidote to arisence poisoning. Its use was continued for many years, although proof of its value was never very impressive. It was applied to bichloride of mercury poisoning, but again, it was not long before it became fairly clear that its value was negligible. You may recall the episode having to do with sodium form aldehyde sulforalate as an antidote to bichloride of mercury poisoning. It began in 1934, and even though some have continued to use it up to

the present time, the indication is fairly clear that the antidote has to be given before the poison in order to provide a conspicuous protective action in systemic poisoning with bichloride of mercury

The long succession of failures of suggested antidotes to metal poisoning was interrupted in the early days of World War II by a series of important discoveries made in rapid succession in the cooperative war programs of chemical, pharmacologic, and clinical research, focused on the problem of an antidote to the arsenical vesicant, lewisite. The chief practical issue was the synthesis of the compound BAL, which is not only highly effective in preventing tissue damage by arsenle and mercury but also in reversing moder ate grades of tissue injury after the metals have been at work for some time

Some of the numerous lines of investigation leading to this discovery were reviewed important steps were necessary before the problem arrived at the point at which an effective antidote became available. One of the earliest observations, bearing most directly on the subsect, was that of Voegtlin, Dyer, and Leonard of the United States Public Health Service who. in 1923, advanced the view that the therapeutic arsenicals produce their effects by combining with the -SH-groups of protoplasm. There were the observations that various enzyme systems depended for their activity on free -SH-group that these ensyme systems could be poisoned by ar senicals, that the combination in some types of thioarsenites could be reversed in alkaline solution, that monothiol and some dithiol com pounds with arsenic were as toxic as the arsenical itself observations leading to the belief that fairly stable but reversible ring compounds might be formed between the arsenical and the -SH groups of tassue proteins or the protein portion of the ensyme systems, that similar but less ensily dissociable compounds of the arsenicals are formed by their interaction with simple dithiols which can compete successfully with the tissue dithiols for the toxic metal

The compound 2,3-dimercaptopropanel, more popularly known as British antilewisite or BAL, is not a harmless material. It is itself a poison It is irritant to the skin and mucous membranes and in large doses causes death with capillary paralysis and shock, sometimes preceded by convulsions. It causes lacrimation, blepharospasm salivation, vomiting, muscular cramps, unrest apprehension, and weakness. Small doses produce arteriolar constriction with elevation of the blood pressure. It is noteworthy that unpleasant effects are produced by doses much below those which may cause serious damage, a fact which provides an element of safety against overdosage BAL is rapidly eliminated in animals and man,

and doses may be repeated in man at intervals of three or four hours without significant cumulation. Studies in man show that some of the minor toxic effects may be produced by doses as small as 3 to 5 mg per Kg, although single doses as high as 8 mg per Kg have been given with safety by intramuscular injection. BAL may be used by most of the common routes of administration, subcutaneous, intramuscular, and intravenous injection, dilute applications to the eye, and by skin inunctions. It is best given by intramuscular injection in the form of a 10 per cent solution in peanut oil

In human poisoning by arsenical compounds, the administration of BAL gives rise to a prompt and marked increase in the arsenic content of the blood which is associated with a marked increase in the arsenic excretion in the urine There now exist convincing reports on the value of BAL as an antidote against the dermatitis, encephalitis, agranulocytosis, and the various febrile reactions due to the arsenicals There is some doubt concerning its utility in arsenical jaundice best results are obtained when the antidote is given fairly promptly after the poison, but it proves effective even after a considerable injury has been produced by the arsenical

The problem has been carried to the field of other metals, and evidence has been obtained in the laboratory that such heavy metals as lead, antimony, vanadium, bismuth, cadmium, mercury, and zincinactivate—SH-containing enzymes and that these effects can be reversed by members of the BAL series

BAL has been applied successfully by Long-cope and his collaborators in the treatment of human cases of bichloride of mercury poisoning Again, while the best results are obtained the sooner the antidote is administered, dramatic relief of symptoms and complete recoveries occurred in patients treated with BAL under conditions

which rarely allowed for recovery with any previous forms of treatment In a fairly large series of cases of poisoning at the Johns Hopkins Hospital in which the patients swallowed 1 Gm or more of bichloride of mercury and were admitted up to four hours later, those treated with BAL all recovered, while the mortality rate in similar controls was about 30 per cent BAL has also been shown to be effective against the toxic effects of the organic mercurial, salyrgan, in the mouse, the cat, and the dog This is of considerable importance in view of the extensive use of these diuretics and the possibility of accidental overdosage

There seems to be very little doubt of the efficacy of BAL as an antidote to arsenic and mercury poisoning—Isolated observations have already been made on the effect of BAL in human poisoning by other metals, copper, zinc, and gold Several rather striking results have been reported on the use of BAL in poisoning produced by gold employed in the treatment of arthritis

Much remains to be learned about the possibilities of thiols in the treatment of poisoning by It may well be that other mervarious metals captans may prove safer and more effective than Since it is likely that clinicians will BAL itself be turning to BAL as a form of treatment of human poisoning by many metals, the experience with cadmium should be borne in mind shown in animals that while the prophylactic administration of BAL eliminated the signs of acute intoxication with cadmium chloride, the animals later succumbed to renal damage in the process of excretion of the cadmium-BAL complex clear from this that great caution is necessary in the application of BAL to poisoning by metals in man and that thorough exploration of the problem relating to any particular metal should be made in animals before BAL is applied in cases of human poisoning

TO ESTABLISH EXPERIMENTAL INSTITUTE

Establishment of an Experimental Biology and Medicine Institute, in the National Institute of Health of the US Public Health Service, has been announced by Oscar R Ewing, Federal Security Administrator

The new research institute will combine the functions of the Division of Physiology and the Pathology and Chemistry Laboratories and will permit greater coordination of scientific investigations

Dr William Henry Sebrell, Jr, chief of the Division of Physiology, has been named director of the new Institute. He will also serve as associate director of the National Institute of Health

Formation of the Institute is part of a wider or-

ganization of the National Institute of Health, Thomas Parran, Surgeon General of the Public Health Service, explained Four other divisions and laboratories engaged in scientific research also will be consolidated into two additional institutes. All of them will be modeled after the National Cancer Institute

The director of the new Institute is an authority in the field of nutrition who has been with Public Health Service since his graduation from the Virginia School of Medicine in 1925—In 1940 he received the Mead Johnson Award of the American Institute of Nutrition, for research on vitamin B complex, and in 1946 was awarded the research medal of the Southern Medical Association

NECROLOGY

Glenn W Arthurs, M.D., of Nisgara Falls died on February 10 at the ago of fifty four An ear nose, and throat specialist in Nisgara Falls for thirty years Dr Arthurs graduated from the University of Buffalo, School of Medicine in 1918 He was on the staffs of Mt St Mary a and Niagara Falls Memorial hespitulas, Niagara Falls I He was a member of the American Medical Association, the Academy of Medicine and the Niagara County and New York State medical societies.

Orris A. Brenenstuhl, M.D., of Albany fifty nine died on February 14 Graduated from Albany Medical College in 1913 Dr Brenenstuhl had served as Albany County coroners physician since 1922. He was assistant surgeon at Memorial Hospital Albany A past president of the New York State Association of Physicians and Surgeons Dr Brenenstuhl was also a member of the Albany County and New York State medical societies and

the American Medical Association

William A. Boyd, M.D., of the Bronx, died on Bebruary 22 He was seventy five years old Dr Boyd graduated from the College of Physicians and Surgeons Columbia University in 1895 He had served on the attending staff of Lincoln Heepital and was a founder and consulting physician of Union Hespital, Bronx. Dr Boyd was a charter member of the Bronx Medical Association, the Bronx County and New York State medical societies and the Society of the Alumni of City Hospital.

Michael Canick, M.D., Brooklyn died on February 14 at the ago of sixty. A graduate of Long Island College Hospital in 1914 Dr. Canick, a member of the American Congress of Physical Medicine was attending proctologist at Both-El Hospital, Brooklyn, and at the Brooklyn Hebrew Home and Hospital for the Aged Formerly associate professor of proctology at Post-Oraduate Medical College, he was also consultant proctologist for the Brooklyn Womens Hospital, as well as chief proctologist for the outpatient department of Beth El Hospital and the Least New York Dispensary, Brooklyn. Dr. Canick was formerly president of the East New York and the Hobrow medical ascittles and belonged to the American Medical Association, Kings County and the New York. State medical societies

Leland Eggleston Cofer, M.D., of New York died on February 17 at his winter home in Palm Beach Florida, at the ago of seventy-nine. Retired from nedical practice several years ago Dr Cofer received his professional training at the Medical College of Virginia graduating in 1880 In 1900 he had charpe of the Viarine Hoepital Quarantine and Immigration Medical Affairs in the Hawalian Islands followed by an eight-year period as the Assistant Surgson General From 1916 to 1921 Dr Cofer was health officer for the Port of New York. 110 had also been director of the Division of Labor Dr Cofer was a member of the American Medical Association American Public Health Association and the New York Academy of Medicine.

Warren Coleman, M.D., of Augusta, Georgia formerly of New York City died on February 13 His age was seventy-eight. Dr Coleman gradu ated from New York University School of Medicine in 1891 and served as an intern at Bellovue Hospital He was a consultant physician for Bellovue and Lenox Hill hospitals Manhattan Dr Coleman was a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians. He was a member of the American Medical Association, the New York County and the New York Academy of Modicine

Louis A. Feldman, M.D., fifty-seven, of Brooklyn, died on February 2 Dr. Feldman a diplomate of the American Board of Ophthalmology received his professional training at the New York University and Bellevue Medical College, graduating in 1014 He was chief of the eye service at Brooklyn Jewish Hospital attending ophthalmologist at the Brooklyn Orphan Asylum and clinical instructor of ophthalmology at Long Island College Hospital. A fellow of the American College of Surgeons and a member of the American Academy of Ophthalmology and Otolaryngology Dr. Feldman also belonged to the American Medical Association and the Kings County and New York State medical secontics.

Robert Rose Gillespy, M.D., died on February 17 at the age of forty nine. He received his medical degree from Tulane University in 1922 Dr. Gillespy served in World War I with the Navy Medical Corps and in World War II was a major in the Army Medical Corps in India. A resident of Garden City Long Island Dr. Gillespy was a member of the medical board of the New York Life Insurance Company

ane Lincoln Greeley M.D of Jamestown, died at the age of eighty-three on January 22 Dr. Greeley graduated in 1897 from the Women a Medical College of the New York Infirmary for Women and Children where she also interned for a year beginning her medical practice in Jamestown in 1898 for many years a member of the American Medical Association Dr. Greeley was also a member of the Training School Committee at the Women's Christian Association Hospital and of the Jamestown, Chautauqua County and New York State medical societies

Alfred Franklin Hocker, M.D., of New York City died at his home on February 12 at the age of forty five Dr Hocker a diplomate of the American Board of Radiology graduated from Louisville University Medical School in 1929 polning the staff of Memorial Hospital in 1930 as an assistant resident surgeon and m 1932 became a research fellow studying cancer and radiology at that hospital. Dr Hocker was noted for his contributions to the development of a treatment for thyroid cancer with radioactive iodine. He also established the tumor clinic at Cornwall New York and was director of that group at the time of his death

Dr Hocker, assistant surgeon at Memorial Hospital was also associate radiotherapist there and at the White Plains Hospital White Plains as well as surgical otolaryngologist in the outpatient department and consultant radiologist at New York Hospital He was also assistant professor of radiology at Cornell University Medical College He was a member of the American Medical Association, the American Radium Society, the National Roentgen Ray Society, and the New York County and State medical societies

Marvin Israel, M D, fifty-six, died on January 8 Dr Israel, a resident of Buffalo, graduated from the University of Buffalo, School of Medicine, in 1914 Following his internship at the Buffalo General Hospital, he pursued a course of postgraduate study in New York City, England, France, and Austria He was appointed to the faculty of the University of Buffalo, School of Medicine, in 1918 A fellow of the American Academy of Pediatrics and a licentiate of the American Board of Pediatrics, Dr Israel was chief of the medical staff of the Sister Elizabeth Kenny Foundation in Buffalo and an active member of the board of the national Sister Kenny Foundation He was attending pediatrician at Children's Hospital, Buffalo, and chief pediatrician at the Salvation Army Women's Home and Hospital, Buffalo Dr Israel was a member of the American Medical Association, the Buffalo Academy of Medicine, and the Eric County and New York State medical societies

Ernest Frederick Krug, M D, of New York City, died at his home February 28 His age was seventy Dr Krug, a graduate of the College of Physicians and Surgeons, Columbia University, in 1900, was a diplomate of the American Board of Ophthalmology An alumnus of Lenov Hill Hospital, Dr Krug also studied in Vienna and Berlin During the first World War he served as a major in the Army Medical Corps Originally an eye, ear, nose, and throat specialist, he limited his practice to ophthalmology in 1922 Formerly an associate professor of ophthalmology at the Post-Graduate School of Medicine and, until 1946, attending ophthalmologist at Post-Graduate Hospital and Dispensary, Dr Krug was consultant ophthalmologist at Lenox Hill Hospital at the time of his death. He was a member of the American Ophthalmological Association, American Academy of Ophthalmology and Otolaryngology, New York Academy of Medicine, New York Ophthalmological Society, and the New York County and New York State medical societies

Erwin Last, M D, of New York City, aged fifty-two, died on February 12 He was graduated from the Medical School of the University of Berne and Vienna in 1919 Dr Last was on the staff of the New York Post-Graduate Hospital and Dispensary He was a member of the American Medical Association, the New York Rheumatism Association, and the New York State and County medica societies

Thomas B Loughlen, M D, seventy-nine, died at his home in Olean on February 25 A graduate of the University of Buffalo, School of Medicine, in 1890, Dr Loughlen was an associate physician on the staff of St Francis Hospital, Olean. He was a member of the American Medical Association, the Cattauraugus County and the New York State medical societies

Henry Kane, M D, of Brooklyn, died at his home on February 10, in his eightieth year. Dr Kane was a graduate of the University of Dorpat Faculty of Moderne, HSSP, in the year 1893.

of Medicine, USSR, in the year 1893 Otto Pfaff, MD, of Oneida, died on February 19 at the age of eighty-four Dr Pfaff, who was reired, graduated from New York University School of Medicine in 1888 He was a physician on the staff of the Oneida City Hospital and a member of the American Medical Association, Syracuse Academy of Medicine, and the Madison County and New York State medical societies

John Wilson Poucher, MD, Poughkeepsie, eighty-eight, died on February 16. A follow of the American College of Surgeons, Dr Poucher received his degree from the Albany Medical College in 1883. Retired from practice, Dr Poucher was formerly abdommal surgeon at Vassar Brothers Hospital, Poughkeepsie, chief surgeon at St Francis Hospital, Poughkeepsie, and consulting surgeon at Highland Hospital, Beacon. He was a member of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, the American Medical Association, the Dutchess County and New York State medical societies.

New York State medical societies

Dr Morris Schoenfeld, MD, sixty-seven, died on January 10 at his New York City home Dr Schoenfeld graduated from Long Island College Hospital in 1903 A founder and former president of the Medical Alliance, Inc., he was for many years an assistant in the allergy department of Stuyvesant Polychine He was a member of the American Medical Association, the New York County and New York State medical societies

Max Seide, MD, of Brooklyn, died on February 23 at the age of forty-nine A graduate of New York Homeopathic School of Medicine in 1927 and an alumnus of Metropolitan Hospital, New York City, and Coney Island Hospital, Brooklyn, Dr Seide had been medical superintendent of Cumberland Hospital, Brooklyn, since 1935

Louis M Smirnow, MD, Brooklyn, died on February 22 His age was sixty-eight Dr Smirnow graduated from Yale Medical College in 1900 He was a member of the American Medical Association, and the Kings County and New York State medical societies

J Bentley Squier, M D, died on March 1 at his New York City home at the age of seventy-four Director emeritus of urology at Presbyterian Hospital and former president of the American College of Surgeons, Dr. Squier graduated from the College of Physicians and Surgeons, Columbia University, m 1894, and was also an alumnus of St Luke's Hospital and Sloane Hospital for Women, New He was a founder and a regent of the Ameri-Yorkcan College of Surgeons From 1909 to 1924, he was professor of genitourinary surgery at New York Post-Graduate Medical School and assumed the professorship of urology at Columbia University in 1917, returning from the Columbia faculty in 1939 Dr Squier was a member of the General Medical Board of the Council of National Defense and served as a major in World War I He had been attending surgeon in urology at Presbyterian Hospital and New York Post-Graduate Hospital, consul ag surgeon at St Luke's Hospital, and consulting gentourinary surgeon at Roosevelt Hospital, in addition to holding the position of director of the J Bentley Squier Urological Clinic at the Columbia-Presbyterian Medical Center Dr Squier was a diplomate of the American Board of Urology, and a member of the American Association of Genito-Urinary Surgeons, the American Urological Association, the New York Academy of Medicine, the American Medical Association, and the New

York County and New York State medical societies
Henry M Stock, M D, formerly of New York
City, died on February 7 at St Augustine, Florida.
Dr Stock was a graduate of the College of Physicians and Surgeons, Columbia University, in 1898

MEDICAL NEWS

Regional Health Officers Appointed

A PPOINTMENT of regional health officers to head the six newly established New York State Health regions was announced February 16 by Dr Herman E. Hilleboe State Health Commissioner

Appointees were named as follows Dr Archibald S. Dean, Buffalo Buffalo Health Region, Dr Josoph P Garen, Rochester, Rochester Health Region, Dr Ray D Champlin, Oncoata, Syracuse Health Region Dr Ralph M Vincent, Binghamton, Albany Health Region Dr Robert L. Vought, Saranac Lake, New York City Suburban Health Region, and Dr Philip J Rafic, Forest Hills, New York City Metropolitan Health Region.

Each appointment is effective March 16 and opening of regional offices will take place as soon thereafter as possible. The appointments are based on the results of a recent civil service promotion examination, and the salary range is \$7 000 to \$8,500 Offices of the five upstate health regions will be

located at Buffalo, Rochester Syracuse Albany, and New York City The sixth region, which will serve New York City only will also have offices there.

The areas to be supervised by each of the upstate

regional offices are as follows
Buffalo Region—Niagara Eric Gonessee Wyoming, Chautauqua, and Cattaraugus counties. Rochester Region-Orleans, Monroe vingston, Ontario Yates, Seneca

Rivingston, Ontario Yates, Seneca Allegany Steuben, Schuyler and Chemung counties. Syracuse Region—St Lawrence Jefferson Lewis Ownego Oneida, Herkimer Cayuga Onondaga, Madison Tompkins, Cortland Chenaugo Tioga, and Broome counties.

Albany Region-Clinton Essex, Warren, Hamil-Saratoga Fulton Washington Franklin

Montgomery, Schenectady, Otsego Schoharie Albany, Rensselaer, Delaware Groene, and Columbia counties

New York City Suburban Region—Sullivan, Dutchess Orange Putnam, Rockland, Ulater, Westchester Nassau and Suffolk counties. New York City Metropolitan Region-Manhat-

tan, Bronx, Kings, Queens and Richmond counties. The regional offices will provide consultation serv ice to the staffs of the State health district, county and city health departments within the region and assist in program planning. They will also help with the development of these local units and observe for the State Health Department the activities of the local health departments which will render

direct service to the people within the region The evaluation of work done by State health districts and local full-time health offices, and the interpretation of policies and procedures in these offices as formulated by the State Health Department in conference with local health officials, will be among the principal duties of the regional health He will also assist in the planning of proofficer grams to be undertaken by the local health units within the region. Consultation with and emer gency assistance to them will be another responsi bility

Provision has already been made for the regional health office to include among its personnel besides the regional health officer a regional tuberculosis control officer, a regional venereal disease control officer and the necessary stenographic staff in most instances two stenographers. Future need for a regional supervising nurse a regional sanitary engi neer and other consultants are foreseen in the planning.

NYU Starts Lecture Series for Family Doctors

A COMMUNITY project to aid family doctors in keeping abreast of rapidly advancing medical developments was inaugurated March 1 at the New York University College of Medicine Dr William Goldring, chairman of the committee on science and education of the College Alumni Association and sponsor of the plan announced.

Heart disease, psychiatry, anesthesia, dermatol ogy, and rehabilitation and physical medicine will be comprehensively treated in 24 clinical sessions open, free of charge, to members of the medical profession with New York University College of Medicine

faculty members in charge. The clinics are to be conducted throughout March,

April and May

Twenty-one College of Medicine faculty members will present the clinics all of which occur for the convenience of practicing doctors, either from 4 to 6 in the afternoon or 8 to 10 at night. One hour of the two-hour sessions will be used for presentation of subject matter, using patients in clinical procedure and the second hour used for open forum discussion in question and answer fashion.

Each special area of medicine will be presented comprehensively over a period of either four or six weeks with the following sessions scheduled heart disease six sessions, two hours each skin diseases six sessions, two bours each psychlatry, four sessions, one hour each, rehabilitation and physical medicine four sessions two hours each.

Dr Scheele Named Surgeon General

DR. LEONARD A. Scheele head of the National Cancer Institute and now sorving as assistant surgeon general, has been appointed Surgeon General of the United States Public Health Sorvice He will succeed Dr Thomas Parran who held the post for 12 years and whose term expires April 6. The appointment was made by President Truman

Termed by Dr Parran as one of the outstanding figures in public health in this country Dr Scheele will assume his new duties at the close of Dr Par rans term of office.

During his 12 years in office, Dr Parran started the National Cancer Program the National Venereal Disease Control Program, the National Tuber culosis Control Program, the National Mental Health Control Program, the National Hospital Survey and Construction Program, and during the war the United States Cadet Nurse Corps,

UN Plans Drive to End Tuberculosis

LARGE-SCALE program to stamp out tuber-A culosis by immunizing 15,000,000 persons will be undertaken by the World Health Organization, it was announced at United Nations Headquarters, Lake Success, recently The program, which was mapped out at the group's meeting in Geneva, will be correct out to account the second out to account the second out to account the second out to account the second out to account the second out to account the second out to account the second out to account the second out to account the second out to account the second out to account the second out to account the second out to account the second out to be s be carried out in conjunction with the United Nations Children's Emergency Fund.

Within the next eighteen months, it is planned, 200 expert medical teams will carry out the immunization program, which the World Health Organization estimates is "the largest single mass immunization ever undertaken". The joint program was arranged after Dr. Ludwik Rajchman, chairman of the Children's Fund's executive board, testified that 70 per cent of all children under 14 years of age were infected by tuberculosis in the war-devasted coun-

The Children's Fund has received \$40,000,000 to date, but is expected to double this sum by the end of the year Of this amount 10 per cent will be de-

voted to medical work

Cornell Offers Industrial Psychiatry Fellowship

PIONEER program to train psychiatrists for the industrial and labor relations field was announced recently at Cornell University by Dean M P Catherwood of the School of Industrial and Labor

Described as the first of its kind, the project will be inaugurated with an industrial psychiatry fellowship offered in the school under a supporting grant from the Carnegie Corporation

The fellowship will be awarded to a physician with experience in psychiatry and will provide two years of training at the school In addition to classroom study in basic industrial and labor relations courses, the fellow will receive training in human relations work in a plant, labor union, or government office

This fellowship and others, planned as the program advances, are expected to help relieve a shortage of trained personnel in the field, according to Dr Alexander H Leighton, Cornell psychiatrist who originated the plan

Only a dozen psychiatrists are practicing today in industrial and labor relations, Dr Leighton estimated, and not all of them are engaged in the work on

a full-time basis

Long Island College of Medicine Lists Appointments

'WO promotions and a list of 17 new appointments I to the teaching staff of the Long Island College of Medicine have been announced by Dr Curran, president of the medical school Jean A

The appointments, recently approved by the College's Board of Trustees, enlarge the College's faculty to 436 members engaged in full or part-time

instruction of students

Dr Curran also announced the resignation of Dr J Raymond Johnson, acting professor of physiology, who left on February 1 to become professor of physiology at the University of Ottawa School of Medi-

The two promotions included the advancement of Dr Herbert C Fett from clinical professor to professor of clinical orthopedic surgery, and Dr Louis Berger from assistant professor to associate professor of clinical surgery

Among those on the list of new appointments were

Department of anatomy Llewellvn T Evans. assistant professor

Department of medicine Meyer A. Rabinowitz, associate professor of clinical medicine, Edmund L Shlevin, Alexander H Louria, and Leo Loewe, assistant professors of clinical medicine

Department of surgery Henry W Louria and Rudolph Nissen, assistant professors of clinical surgery, Saul Schapiro and Irving M Pallin, instruc-

tors in clinical surgery

Department of radiology Milton G Wasch, associate professor of clinical radiology, Bernard S Epstein, instructor of clinical radiology

Department of preventive medicine and community health L Holland Whitney, assistant professor, Jene B Aronson, Marta Fraenkel, associates, Eva Landsberg, instructor, Lawrence Kuskin, assistant

Department of urology Paul Aschner, assistant professor of clinical urology

MEETINGS

PAST

Physicians Forum

A proposal to amend the constitution of the American Medical Association to admit to membership any qualified physician regardless of race, aimed to eliminate discriminatory practices against Negro physicians, was presented at a meeting of the Physicians Forum at the New York Academy of Medicine on February 4.

The proposal was presented by Dr Curtis Flory, assistant professor of pathology at the Cornell University Medical College and chairman of the Physicians Forum's Committee on Civil Rights in Medicine

Other speakers at the meeting, which dealt with "the plight of the Negro physician in American medicine," were Dr Alfred E Cohn, member emeritus of the Rockefeller Institute for Medical Research, and Dr W Montague Cobb, professor of anatomy at Howard University, Washington, D C

[Continued on page 656]

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[Continued from page 654]

Dr George Cannon, national secretary of the Physicians Forum, presided

Saranac Lake Medical Society

Guest speakers have featured the weekly meetings of the Saranac Lake Medical Society, held at the

Saranac Laboratory on Wednesday nights
At the February 18 session, Dr Robert L Yeager,
medical director, Summit Park Sanatorium, Pomona, presented a paper on "Nontuberculous
Chronic Chest Disease"

Dr Frank Glenn, professor of surgery, New York Hospital, Cornell University Medical School, spoke on "Surgical Problems of Biliary Tract Disease" at the February 25 meeting, and Dr Benjamin Kramer, professor of pediatrics, Long Island College Medical School, spoke on "The Pneumonias of Infancy" at the March 3 meeting

New York Psychoanalytic Society

Dr Fritz Wittels spoke on "A Neglected Boundary of Psychoanalysis The Inner Experience" at the meeting of the New York Psychoanalytic Society held February 24 in New York City

Association for the Advancement of Psychotherapy

At the regular monthly scientific meeting of the Association for the Advancement of Psychotherapy, held February 27 at the Academy of Medicine, New

York City, a motion picture on "Postwar Psychiatry in the Army What it Teaches the Civilian Psychi atrist" was shown

Dr Donald B Douglas made the introductory comment

Eastern New York Eye, Ear, Nose and Throat Association

Guest speakers at the meeting of the Eastern New York Eye, Ear, Nose and Throat Association on March 4 in Albany were Dr Gordon D Hoople,

Syracuse, and Dr Joseph I Pascal, New York City Professor of otolaryngology at Syracuse University Medical College, Dr Hoople spoke on "Prevention of Deafness and Conservation of Hearing" Dr Pascal, who is director of ophthalmology at the Stuyvesant Polyclinic, presented "A Graphic Study of the Ocular Muscles"

Society of Medical Jurisprudence

"Problems of the Medical Examiner's Office" was the topic presented by Dr Thomas A Gonzales, chief medical examiner, New York City, at the meet-ing of the Society of Medical Jurisprudence, held March 8 at the New York Academy of Medicine

Dr Theodore J Curphey, chief medical examiner, Nassau County, discussed the topic from the medical standpoint, and Mr George P Monaghan, head of the Homicide Bureau, New York County, from the legal standpoint

FUTURE

American College of Physicians

A postgraduate course in clinical allergy will be held under the sponsorship of the American College of Physicians at the Roosevelt Hospital, New York City, from May 17 to 28 A maximum registration of eight will be accepted

Covering a period of two weeks, the course is intended for the general practitioner, the internist, and the pediatrician Cases representing the important diseases of allergy will be assigned to each student for diagnosis and treatment, under supervision

National Gastroenterological Association

The thirteenth scientific session of the National Gastroenterological Association will be held at the Hotel Pennsylvania, New York City, from June 7 to

For the first three days, the program will consist of symposia on gastroduodenal ulcer, ulcerative colitis, jaundice and metabolism, nutrition and allergy A panel discussion will cover the topics of diabetic, tubercular, psychosomatic, and cardiac manifestations in gastrointestinal disease. The fourth day will be a clinical day at cooperating hospitals in New York City

Further details may be obtained by writing to the secretary at 1819 Broadway, New York City 23

American Society for the Study of Sterility

The American Society for the Study of Sterility will hold its fourth annual national session on June 21 and 22 at the Congress Hotel in Chicago man will be Dr Edwin G Robertson, chairman of the department of obstetrics and gynecology of

Queens College, Ontario, Canada Information may be obtained from the secretary, Dr John O Haman, 490 Post Street, San Francisco

2, California

[Continued on page 658]

East New York Medical Society

The East New York Medical Society will meet on April 5 at 9 PM. at the Kings County Medical Society building Speaker will be Dr Louis Reis Davidson, thoracic surgeon, Post-Graduate Hospital, and director of surgery, Sea View Hospital, who will present "Recent Advances in Surgery of the Chest "

University of Buffalo School of Medicine

The Alumni Association of the University of Buffalo School of Medicine will hold its annual Spring Clinical Day on April 17 at the Hotel Statler, Buffalo

New York Academy of Medicine

Results of original research in clinical medicine will be presented at the meeting of the New York Academy of Medicine on April 29, under the sponsorship of the Committee on Medical Education of the Academy

American Congress on Obstetrics and Gynecology

The international and fourth American Congress on Obstetrics and Gynecology will be held May 14 to 19, 1950, at the Hotel Pennsylvania, New York City

Although the meeting is more than a year away, tentative plans have already been announced for technical and scientific exhibits, motion pictures, and educational programs Executive offices of the Congress will be at 24 West Ohio Street, Chicago 10, Illinois

Dr Fred L Adair will act as chairman of the Congress, and any inquiries can be sent to him at the Congress headquarters Dr George W Kosmak, of New York, is chairman of the finance committee and Dr Howard C Taylor, Jr, chairman of the committee on program

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[Continued from page 656]

Wyoming State Medical Society

The annual meeting of the Wyoming State Medical Society will be held in Laramie, Wyoming, on September 1, 2, and 3

American Occupational Therapy Association

The Hotel Pennsylvania, New York City, will be

the site this year of the annual convention of the American Occupational Therapy Association. On September 7, 8, and 9, the program will include registration, open meetings, round tables, and field trips, according to a recent announcement by the Association

On September 10 and 11, an institute will be held

by the Association

PERSONALITIES

Awarded

Dr H W Brown, Columbia University, renewal of a Sharp and Dohme research grant, for testing various compounds for antimalarial and antiparasitic effects Dr Edward S Godfrey, former State Commissioner of Health, an honorary life membership in the American Social Hygiene Association in recognition of his service "in the promotion of voluntary health and welfare agencies"

Elected

Dr Robert L Levy, professor of clinical medicine, Columbia University, College of Physicians and Surgeons, as president of the New York Heart Association

Appointed

Dr Dicran A Berberian, former chairman of the department of bacteriology and parasitology at the American University, Beirut, Lebanon, as senior investigator in the department of chemotherapy of the Sterling-Winthrop Research Institute, Rensselaer Dr Robert Boggs, formerly assistant dean, as acting dean of the New York Post-Graduate Medical School Dr Wade W Oliver, former professor of bacteriology, Long Island College of Medicine, as associate director of the Division of Medical Sciences of the Rockefeller Foundation Colonel Walter S Pugh, chief medical officer of the Veterans Administration, Syracuse, as commander of the 343rd General Hospital, Organized Army Reserve Corps, Syracuse

Speakers

Dr Maurice M Black, assistant chief pathologist, Brooklyn Cancer Institute, who discussed "How

Modern Medicine Can Help the Layman" on March 2 before a group of the Brooklyn College Adult Education Division Dr Bernardo A Houssay, director, Institute of Biological Research, Buenos Aires, Argentina, who gave the annual John Wyckoff lectures at New York University College of Medicine February 16 and 17 on "Carbohy drate Metabolism and Diabetes" Dr Samuel Farrar Kelley, assistant professor of clinical surgery, Cornell University Medical College, guest speaker at the International Post-Graduate Medical Assembly of Southwest Tevas, in San Antonio on January 27, 28, and 29—spoke on "Rhinoplasty in Otolaryngology," "Sinusitis Associated with Allergy," and "Treatment, Surgical and Nonsurgical, for Otitis Media, Acute and Chronic"

Dr George W Kosmak, New York City, editor, New York State Journal of Medicine, as presiding officer for a session of the social hygiene program at the annual conference of the New York Tuberculosis and Health Association, March 9, in New York City Dr John C Long, Memorial Hospital, and Dr Abraham Oppenheim, Harlem Hospital, at the exhibit on cancer research held at Hunter College, New York City, March 1 to 5

New Offices

Dr Edward J McGuinness, Jr, veteran of four years' service with the Army Medical Corps in the European Theater, former staff member of Kingsbridge Veterans Hospital, the Bronx, general practice in Manhasset Dr Albert Mazzeo, former Army captain, general practice in Newburgh Dr M P Pestillo, Army veteran, practice of pediatrics in Syracuse Dr William R Walsh, New York City, general practice in Moravia

COUNTY NEWS

Albany County

Dr Lloyd F Craver, associate professor of clinical medicine, Cornell Medical College, was the guest speaker at the meeting of the Albany County Medical Society February 25 at the Albany College of Pharmacy His topic was "Advances in the Treatment of Malignant Lymphomas and Leukemias." Discussion following the talk was led by Drs William P Howard and John J Marra

Three Albany County medical projects totaling nearly \$13,000 have been approved by the American Cancer Society They include thyroid cancer registry, \$2,500, Albany Hospital tumor climic and two fellowships in tumor pathology, \$5,300, and research program in high mammary strain of rats, \$5 138

Broome County

At the January meeting of the Broome County Medical Society, held at the Binghamton City Hospital, a panel discussion on "Early Ambulation" was conducted under the leadership of Dr. H. W. Hobbs

William F Martin, New York City, trial counsel for the Medical Society of the State of New York, addressed the annual joint dinner meeting of the Broome County Bar Association and the Broome County Medical Society January 31, in Binghamton

Program committee for the meeting included Dr Raymond S McKeeby, chairman, and Drs J C Zillhardt and Robert Bogdasarian

Canandaigua County

Dr Charles J Bobeck was elected president of the [Continued on page 660]



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CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 J.Ū.
IRON	12.0 mg	COPPER	0.50 mg.

*Based on average reported values for milk.

Canandaigua County Medical Society, succeeding Dr Malcolm R. Blakeslee, at the annual election of officers and meeting held in January at the home of Dr and Mrs Augustus W Samsbury, Canandaigua

Dr Sainsbury is the new vice-president, and Dr Griffith J Winthrop is secretary-treasurer

Cayuga County

"Recent Advances in Administration of Penicillin and Streptomycin" will be presented by Dr Paul A. Bunn, associate professor of medicine, Syracuse University College of Medicine, at the meeting of the Cayuga County Medical Society March 18 at 7 PM at the Osborne Hotel, Auburn

Clinton County

Dr Frederick T Schnatz, assistant professor of medicine, University of Buffalo School of Medicine, spoke on "The Treatment of Persistent or Recurrent Dyspnea" at the January meeting of the Clinton County Medical Society, and at the February meeting, Dr George H Marcy, instructor of orthopedies, University of Buffalo, spoke on "The Treatment of Low Read Page"." Low Back Pain'

Chemung County

The Chemung County Medical Society has endorsed the program outlined by the county cancer control unit to set up cancer clinics in the St Joseph's and Arnot-Ogden hospitals in Elmira, under supervision of the American Cancer Society

Cortland County

"Some Recent Advances in Therapy" were discussed by Dr Richard H Lyons, professor of medicine, Syracuse University, at the meeting of the Cortland County Medical Society, held February 20

Dutchess County

A dinner meeting in honor of Dr Robert W Andrews, Dr James Cronk, Dr F Howell Greene, and Dr C J Slocum was held February 12 at the Nelson House, Poughkeepsie, by the Dutchess County Medical Society

Dr Chfford A Crispell was chairman of the com-

mittee on arrangements

Erie County

Dr Berwyn F Mattison, Yonkers, new Health Commissioner for Eric County, spoke at the meeting of the Erie County Medical Society, February 24, in Buffalo, outlining his programs and policies and discussing the structure of the new County Health Department

The nineteen living past-presidents of the County Society were recipients of the Past-President's Key at the meeting, the presentation being made by Dr

E Dean Babbage, president

E Dean Babbage, president
Past-presidents honored included Dr Daniel V
McClure, 1911, Dr James F Whitwell, 1913, Dr
Irving W Potter, 1917, Dr Robert E DeCeu,
1926, Dr W Warren Britt, 1927, Dr Edward
A Sharp, 1933, Dr Herbert H Bauckus, 1935, Dr
Milton G Potter, 1936, Dr John T Donovan,
1937, Dr Harry C Guess, 1938, Dr Carlton E
Wertz, 1939, Dr Herbert E Wells, 1940, Dr
Nelson W Strohm, 1941, Dr Harvey P Hoffman,
1942, Dr Harold F R. Brown, 1943, Dr John D
Naples, 1944, Dr A. H Aaron, 1945, Dr Porter

Naples, 1944, Dr A. H Aaron, 1945, Dr John D.
Naples, 1944, Dr A. H Aaron, 1945, Dr Porter
A. Steele, 1946, Dr Arthur F Glaeser, 1947
The program for the March 23 meeting of the
County Society will include a talk by Dr Wallace
B Hamby, whose subject will be "Diagnosis and
Management of Subarachoud Hemorrhage" Discussion will be led by Dr Nelson G Russell, Sr, and Dr Irving Hyman

One hundred forty physicians in Buffalo and Eric County have enrolled as members of the Speakers Bureau of the Eric County Chapter, American Cancer Society, in response to requests of Dr Arthur F Glaeser, president of the County Medical Society, and Dr Samuel Sanes, chairman of the Society's Cancer Control Committee

Franklin County

Dr Frederick N Marty, assistant professor of clinical medicine, Syracuse University College of Medicine, spoke on "Blood Substitutes and Derivatives" at the meeting of the Franklin County Medical Society March 4

Fulton County

Facial surgery was discussed at the January meeting of the Fulton County Medical Society held in Gloversville Dr John Converse, New York City, gave a lecture dealing with plastic surgery of the face, and Dr Byron Smith, also of New York City, spoke on burns of the eye

Greene County

Dr William A Petry, Catskill, was elected president of the Greene County Medical Society

Other officers are Dr Michael Viviano, Tannersville, vice-president, Dr William M Rapp, Catskill, secretary, and Dr Mahlon H Atkinson, Catskill, treasurer

Jefferson County

Postgraduate instruction arranged by the Council Committee on Public Health and Education of the

State Society was given March 11 in Watertown
Dr Wardner D Ayer, professor of clinical medicine, Syracuse University College of Medicine, spoke
on "Neurology in General Practice"

Sponsored by the Jefferson County Medical Society, a tumor clinic, the first of its kind to be established in northern New York, was opened January 20 in Watertown, under the supervision of

of the American Cancer Society

Dr H C Montgomery is executive director of the clinic, and the present staff includes Dr H N Cooper, Dr Thomas P Hamilton, and Dr Thomas P. Soleka eller all morphore of the County Secrety Cons N Sickels, all members of the County Society Can-

cer Committee

Kings County

"Current American Medical Association Activities" will be discussed by Dr George F Lull, secretary and general manager of the AMA., at the Kings County Medical Society meeting March 16

Madison County

A series of Thursday evening meetings with postgraduate instruction arranged by the State Society Council Committee on Public Health and Education will be held at the Hotel Oneida, Oneida, for the Madison County Medical Society Each session will begin at 8 30 pm Meetings will include March 18—Dr Walter F Bugden, assistant professor of clinical surgery, Syracuse University College of Medicine, "Diagnosis and Troatment of Surgical Lesions of the Esophagus" March 25—Dr Robert O Gregg, assistant professor of surgery, Syracuse University College of Medicine, "Surgery of the Stomach" April 1—Dr Albert D Kaiser, professor of child hygiene, University of Rochester, School of Medicine and Dentistry, "Rheumatism in Childhood." Council Committee on Public Health and Education

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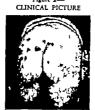
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REFERENCES

Cooke, J V Brennemann Practice of Pediatrics 4: Chapter 41 1945

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HOSPITAL NEWS

Plastic Surgery Clinic Opened at Syracuse

PLASTIC surgery clinic, first of its kind in Syracuse, was opened in January at the Syracuse free dispensary to make available to the indigent the advantages of a science aimed at eliminating or minimizing the effects of physical deformities, it was announced by Dr H G Weiskotten, dean of the College of Medicine, Syracuse University

The clinic will be conducted at 11 AM every Wednesday, with a plastic surgeon certified by the American Board of Plastic Surgery in charge

It was stressed that in making the advantages of plastic surgery available to those unable to pay for such services there will be a "follow-through" plan assuring correction of deformities which come to light in clinical examination This means that hospital treatment will be provided and, where necessary, continued care will be given at the clinic once the patient is discharged from the hospital

While most of the nation's biggest cities already have such centers, Syracuse is believed to be the first of its size to establish a plastic surgery clinic for

the low-income group

Importance of the step is emphasized by the fact that, contrary to a rather widespread impression, the primary objective of plastic surgery is not cos-metic in nature, but rather the restoration of func-Improvement of appearance is the second objective of the science

Yeshiva Planning Medical College

ZESHIVA University will establish the first nonsectarian medical school under Jewish auspices in the United States, it was announced early in March by Dr Elihu Katz, chairman of the Society for the Advancement of Pre-Medical Sciences at Yeshiva University

The decision to establish the graduate school was arrived at by twenty-six Christian and Jewish physicians, business men, and educators after "a recent authentic government report estimated that there will be, by the present tactics of exclusion and

discrimination, a shortage of 5,600 physicians in the United States by 1960," Dr. Katz said

The society was formed early this year when it was learned that Yeshiva intended to set up a number of professional schools in conjunction with the university's current \$7,500,000 academic and physical expansion drive

"We determined," Dr Katz said, "that a medical school must be the first of these professional schools Its formation was based upon a practical and factual decision, not emotional, religious and otherwise"

New York's Blue Cross Plan Grants Additional \$1,000,000 to Hospitals

AS A FURTHER step in helping member hospitals to meet their current financial difficulties Associated Hospital Service—New York's Blue Cross Plan-will grant an additional payment of \$1,000,000 for the care of Blue Cross patients during the first four months of 1948, it was announced recently by Louis H Pink, president The extra payment, approved by the State Department of Insurance and the Department of Social Welfare, is the second granted to hospitals in recent months Last November AHS paid hospitals an additional sum of \$1,300,000 to meet increased costs during 1947

Pointing out that the loss of approximately \$14,-000,000 now incurred by voluntary hospitals in New York City is largely due to free or part-free services, Mr Pink stressed the need for immediate State aid to voluntary hospitals as well as to public hospitals and increased payments from the City for its cases Of the total loss, he declared, city cases alone amount

to about \$5,000,000

"AHS has increased the income of hospitals by enabling people of moderate means to obtain better accommodations We have compensated the hospitals for substantial numbers who would not be able to pay their hospital bills and would therefore be added to the charitable load

Other advantages which the hospitals receive from Blue Cross include utilization of empty beds, prompt payment, and avoidance of collec-tion losses"

\$161,580 More Allotted for New York City Projects

DDITIONAL grants totaling \$161,580 to ten A DDITTONAL grants woming officers and New York City projects in cancer research and service were announced in March by Brigadier General John Reed Kilpatrick, chairman of the joint New York City Cancer Committees of the American Cancer Society

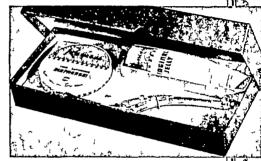
The new grants, derived from contributions to last year's fund-raising campaign, bring total committee allocations in the city to \$440,580 In addition, \$528,108 has been turned over to the society for its national program of basic research and education

Largest new grant was \$109,000 to Memorial Hospital for Cancer and Allied Diseases Other institutions which benefited were the night tumor clime at New York Post-Graduate Hospital, Strang Clime of the Women and Children's Infirmary, New York University Medical School, Columbia University and Columbia's College of Physicians and Surgeons, Lenox Hill Hospital, the National Hospital for Speech Disorders, and the tumor clinics of Roosevelt and Presbyterian Hospitals

[Continued on page 664]

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†Human Fertility 10 25 (Mar.)

[Continued from page 662]

Wards in 69 Voluntary Hospitals Have Beds for 30 Per Cent More Patients

'HE public wards in New York's voluntary hospi-Tals were only 70 per cent filled during the first nine months of 1947, it was learned recently from the United Hospital Fund, 370 Lexington Avenue

While some of the city's municipal hospitals were overcrowded to more than their maximum capacity, the occupancy rate in the "general" wards of 69 of the city's voluntary institutions reached a low point of 64 per cent in August, according to figures prepared by the fund

During the three busiest months of the year, from January through March, the voluntary hospitals were filling their 9,080 general-ward beds at an

average rate of 73 per cent

With the rate for operation at greatest efficiency considered to be between 80 and 85 per cent, some of the city's largest voluntary hospitals-privately run institutions partly supported by public contri-butions—were running at considerably below that level in their public wards

In Manhattan, the Lenox Hill Hospital was filling

61 per cent of about 300 public beds in September In the same month, the Mount Sinai Hospital's occupancy rate was 66 per cent of about 475 public beds, St Luke's, 70 per cent of about 340, St Vincent's, 73 per cent of about 330, and in the New York Post-Graduate and Roosevelt hospitals, 75 per cent of more than 290 and 225 public beds, respec-

In the same month, the general wards in the New York Hospital, with more than 590 public beds, were filled at the rate of 82 per cent, and in the Presby-terian Hospital, with more than 860 public beds, at the rate of 81 per cent During February, the same beds in the New York and Presbyterian Hospitals were 91 and 86 per cent occupied, respectively

At the rate of two patients a bed each monthwith "active" patients remaining in the hospital about two weeks—the 69 voluntary institutions listed by the fund could have accommodated March operating at 100 per cent capacity, or 6,000 more patients during September

NYU-Bellevue Medical Center Construction to Start in 1948

LEARANCE of the site for the University section of the New York University-Bellevue Medical Center, and construction of some of the new buildings will commence by mid-summer or early fall of this year, according to Edwin A. Salmon, director of the Medical Center, and former chairman of the New York City Planning Commission

Revealing for the first time details of construction plans, Mr Salmon said the architectural style of the buildings will be modern and functional, and that materials will be steel and reinforced concrete, with a warm-toned limestone and brick exterior

First buildings on which construction will be

started will be the hall of residence, the alumni hall, and new clinical laboratories and classrooms for the College of Medicine The hall of residence, he said, will provide approximately 300 dormitory rooms for undergraduate and graduate medical students, particularly those whose services at Bellevue Hospital require that they be on call at

Special provisions will be made for women students and the nurses of the proposed new University Hospital One wing of the building, overlooking the East River, will be devoted to recreational transfer of the state

tional and dining facilities, he continued

NEWS NOTES

The board of directors of the Tri-County Memorial Hospital, Gowanda, has announced plans for a new building, which will increase the hospital's capacity from 35 patients to 70 patients

The Mount Morris Tuberculosis Hospital was represented by Dr E W Hainlen at the Conference of the Committee on Chemotherapy of the National Tuberculosis Association in New York City recently In January, Dr Hainlen attended the meeting of the Eastern Section of the American Trudeau Society in Philadelphia

Open house was observed at the Onerda County Hospital of Utica, formerly the General Hospital, in January Approximately 500 persons inspected the newly improved premises

Polyclinic Hospital, New York City, has established a male fertility clinic as a component of the urological department. A comprehensive workup, including vesiculographic study of the seminal tract is conducted. Members of the profession are invited to refer suitable cases to the clinic, which will be held on Saturday mornings at 9 00 A.M., according to a recent announcement by Dr Edward L. Kellogg, medical executive officer of Polyclimc Medical School and Hospital

Arrangements have been made for general surgery to be performed at the Mahopac Hospital, according to an announcement by David M Edes, president of the hospital's board of directors Dr William P Cowan, of Cold Spring, requested the privilege of utilizing the Mahopac Hospital for surgery, and permission was granted by the medical advisory board, of which Dr George H Steacy is chairman, in consultation with the executive committee of the hospital

Parkchester General Hospital, the Bronx, has instituted a cancer detection and diagnostic service Patients will be accepted only through their private physicians by appointment, hospitalized for three days while a complete workup is done, and then referred back to the private physicians, to whom all reports will be sent

[Continued on page 666

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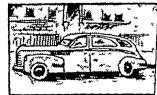
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[Continued from page 664]

At the meeting of the Clinical Society of the Unity Hospital, Brooklyn, on February 25, Dr S Leon Israel, associate gynecologist and obstetrician of the Graduate School of Medicine, University of Pennsylvania, Philadelphia, read a paper on "Functional Uterine Bleeding, Etiology, Diagnosis, and Treatment" Case reports were given by Dr David A Frenkel, on "Sternhty—Uterus Didelphys, Carcinoma in One Horn," and by Dr Harold Jacobs, on "Chorionepithehoma with Metastasis"

A total of 2,503 patients were cared for in the Alice Hyde Memorial Hospital, Malone, during the year 1947, it was stated in the annual report of the hospital A total of 589 babies were born at the hospital during the fiscal year December 1, 1946, to December 1, 1947

Plans have been completed for a tumor clinic building to be erected adjacent to the laboratory in Kingston They were approved at the December meeting of the Ulster County Medical Society

An increase of 245 admissions per year at Ossining Hospital was reported by Mrs A C Richards, superintendent, in the annual report to the hospital's board The hospital had a total of 2,850 admissions in 1947, with 1,941 patients coming from Ossining, 330 from Croton and Harmon, 98 from Briarchiff, and the remaining 481 from other nearby towns

For Hospital, Oneonta, has won back its certificate of full approval from the American College of Surgeons, announced Lewis F Rose, president of the board of directors of the hospital There was an increase of 1,551 patient-days in 1947 at Fox Hospital, and 637 births, or an increase of 113 over 1946

Dr C D Silver, president of the medical staff of Physicians Hospital, Plattsburg, reported on the activities of the hospital at the annual meeting of the board of directors recently. The number of patients treated at the hospital increased 26 per cent to 5,164. The number of babies born was 754, and 1,952 operations were performed. The pediatric division was enlarged from 8 to 18 beds during the past year. The women's ward was modernized, and a new ward for men was opened.

The Lenox Memorial Hospital in Canastota, formerly the Canastota Memorial Hospital, reopened in February It is now under the direction of Miss Beatrice Facteau, according to an announcement by Antonio G Waldo, chairman of the board of managers

There were nearly four times the number of laboratory tests at St Joseph's Hospital, Syracuse, in 1947 than in 1927, shortly after the completion of the present hospital structure, according to the hospital reports. In 1927 there was a total of 11,890 laboratory tests, while in 1947 there were 45,809. Dr Ellery G Allen is director of laboratories at St Joseph's Hospital. A campaign is now in progress

to add a new wing to the hospital, thereby providing enlarged laboratory and x-ray departments

After a business meeting of the staff of Highland Hospital, Beacon, in January, Dr Charles Reed presented a paper on "X-rays in Respiratory Diseases"

On January 28, Dr Franklin M Hanger, professor of medicine at Columbia-Presbyterian Medical Center, presented a paper on "Disorders of the Pancreas" at the meeting of the staff of Castle Point Veterans Hospital At the February meeting, Dr Ross Golden, professor of radiology at Columbia-Presbyterian Medical Center, discussed tuberculosis of the digestive tract as manifested by \-ray examination

A prize of \$25, accompanied by a certificate of ment, the John W McCauley prize award, will be presented by the Rochester Academy of Medicine for the best case report by any house officer of the staff of any hospital in Monroe County

A joint committee for research in problems of cerebral palsy has been established by Bellevue and Presbyterian hospitals, the City Health Department, Cornell University, Columbia University, College of Physicians and Surgeons, and the New York University College of Medicine Its purpose is to conduct research, intensify the development of diagnostic procedures, and to study clinics

The name "Community Memorial Building" has been selected as the official designation of the new six-story structure to be erected as an adjunct of the Lawrence Hospital, Bronxville, it was announced recently by James A Lyles, president of the hospital's board of governors Dr Henry E McGarvey, president of the medical board of the hospital, has appointed Drs Waring Willis, John E Weston, and Joseph E J King as a planning committee to work with the board of governors in the development of the new building The Lawrence Hospital serves the area that includes Bronxville, Tuckahoe, Eastchester, and parts of Yonkers and Scarsdale

"The Prostate Gland of Men Over Fifty Years Of Age" was the subject of the regular staff conference of St Mary's Hospital, Brooklyn, on February 26

The annual meeting of the board of directors of Tioga County General Hospital, Waverly, was held in January Reports were given by Dr Harry S Fish, chief of the surgical staff, Earl C Cooper, treasurer, and Miss Laura A Ott, superintendent

Dr William Goldring, associate professor of medicine, New York University, College of Medicine, spoke on "The Present Status of the Medical and Surgical Treatment of Hypertension," as the annual Samuel Strausberg Lecture, sponsored by the board of directors and the Clinical Society of the Beth-El Hospital, Brooklyn, in February

[Continued on page 668]

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[Continued from page 666]

PERSONALITIES

Appointed

Dr H E Leiter as attending urologist at the Hospital for Joint Diseases, New York City To the staff of the Mount Morris Tuberculosis Hospital, Dr Ricardo Valiente, from El Salvador, Central America To the surgical staff of the Clifton Springs Sanitarium, Dr Bradley Simmons, from the Strong Memorial Hospital, Rochester Dr Lewis S Blancato, recently discharged from the Army Medical Corps, to the staff of the Mt Vernon Hospital Dr Sigmund L Friedman, executive director of Sydenham Hospital, New York City, since February, 1947, as director of Mount Sinai Hospital, Cleveland, Ohio Dr Clarence E de la Chapelle, associate dean of New York University College of Medicine, as director of medicine at Lenox Hill Hospital, New York City Dr Eliot M Friedman, Utica, specialist in orthopedic surgery, to the consulting staff of Oneida City Hospital, Richmond, Dr Gerald T McCarthy, and as assistant orthopedic surgeon, Dr Alfonso Della Peltra Dr Robert R. Cadmus, administrative assistant at New York Presbyterian Hospital since

assistant director, Cleveland University Hospital
Dr Robert Boggs, assistant dean of New York
University College of Medicine, as acting dean of the
New York Post-Graduate Medical School As
clinical assistant in the department of medicine,
Richmond Memorial Hospital, Dr A D Workman

Elected

As officers of Memorial Hospital, Catskill, Dr Ray E Persons, president, Dr Kenneth F Bott, vice-president, and Dr George L Branch, secretary Other members of the board are Drs Mahlon H Atkinson, Alton B Daley, Edwin Mulbury, and William A Petry Dr George J Hucker as first vice-president of the Geneva General Hospital Corporation As president of the medical staff of Champlain Valley Hospital, Dr Arthur B de Grandpre As officers of the medical staff of Northern Dutchess Health Service Center, Dr W P Locke, Hyde Park, chief of medical staff, Dr David Block, Madalin, vice-president, and Dr L Cotter, Red Hook, secretary Dr Charles L Reigi as president, medical staff of St Vincent's Hospital, Richmond, Dr John J Goller as secretary, Dr Enrico C Soldini as vice-president

DR. FISHBEIN CITED FOR WAR WORK BY PRESIDENT TRUMAN

Dr Morris Fishbein, editor of the AMA Journal, recently was awarded a Certificate of Merit by President Truman in recognition of his "outstanding efforts as Chairman of the Committee on Information of the National Research Council, which proved to be an invaluable contribution to the war effort of the United States"

1945 and director of Vanderbilt Clinic there, as

In notifying Dr Fishbein of the award, Commander G E Pierce, of the US Navy, secretary of the Civilian Awards Board in Washington, said it is given to "civilians for outstanding fidelity and meri-

torious conduct which aided in the war effort against common enemies of the United States and its allies in World War II"

The Certificate of Merit was presented to Dr

The Certificate of Merit was presented to Dr Fishbein at a brief ceremony in the AMA head-quarters building with Rear Admiral J Carey Jones, Commandant, Rear Admiral F L Conklin, MC, District Medical Officer, and other prominent Navy personnel from the Ninth Naval District at Great Lakes, Illinois, in attendance—Secretary's Letter, AMA, January 26, 1948

ANNOUNCEMENT

1948 Medical Directory Deadline

All material for the 1948 Medical Directory of New York, New Jersey and Connecticut should be in the office of the Medical Society of the State of New York before April 15, 1948

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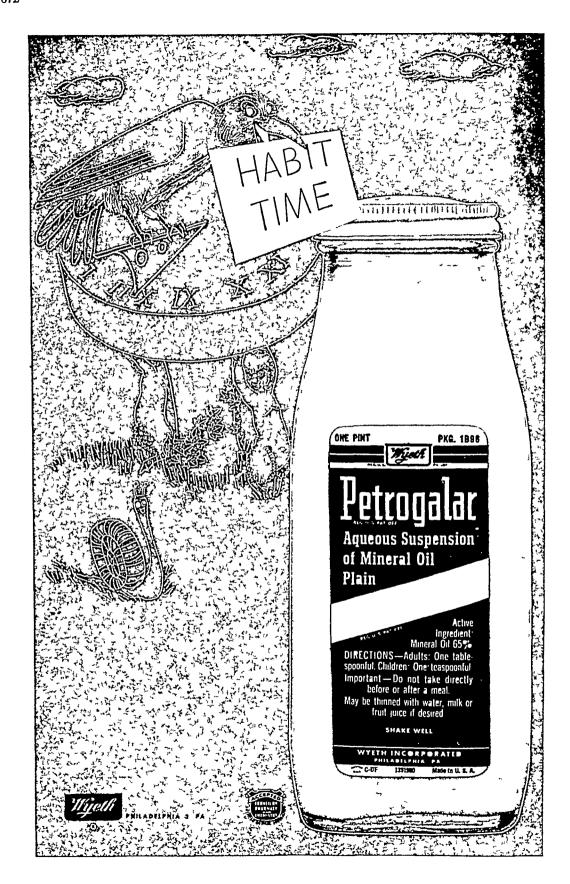
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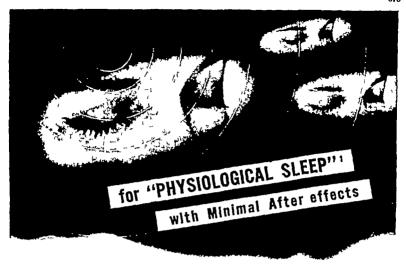
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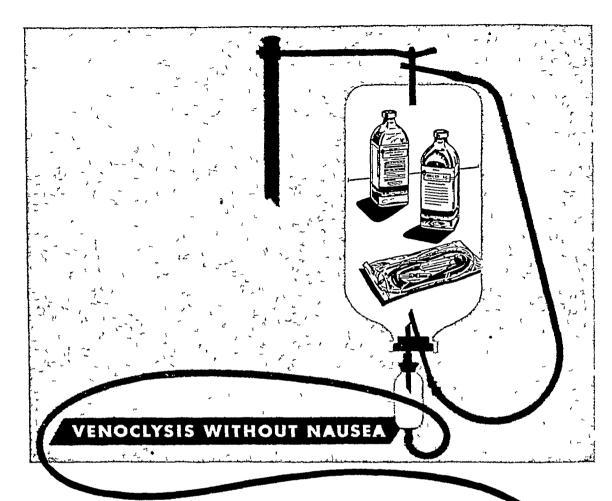
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19.N.R., 1947 p. 398.
*Conductor, I., & Gilsens A., The Phermocological Basis of Therapostics, MacMillan, 1944, pp. 177-5.



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- *Madden, S. C., et al. Tolerance to Amino Acid Mixtures and Casein Digests Given Intra venously Glutamic Acid Responsible for the Reactions, J. Exper. Med. 81 439 (May) 1945
- **Smyth, C J Lasichak, A G and Levey S.. The Effect of the Rate of Administration of Amino Acid Preparations and Blood Amino Acid Nitrogen Level on the Production of Nausea and Vomiting J Lab and Clin. Med 32.889 (July) 1947

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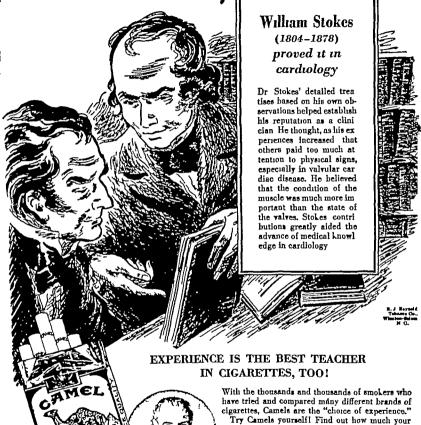


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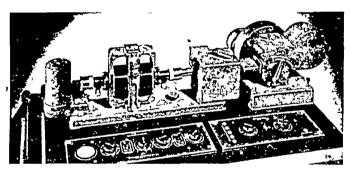
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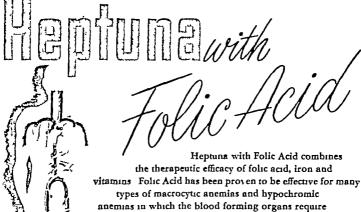
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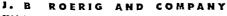
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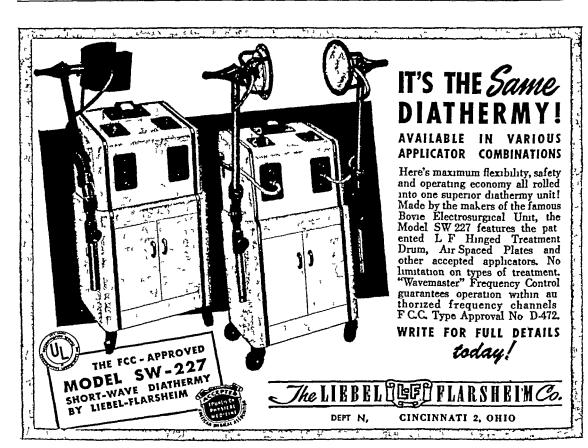


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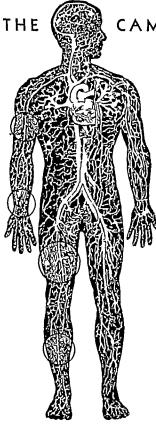
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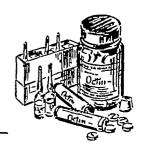
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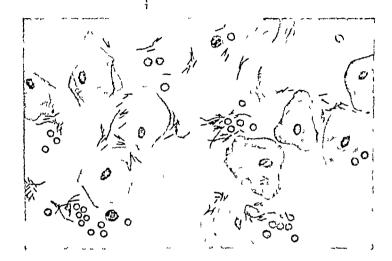
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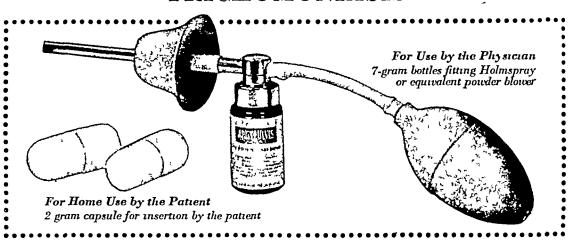
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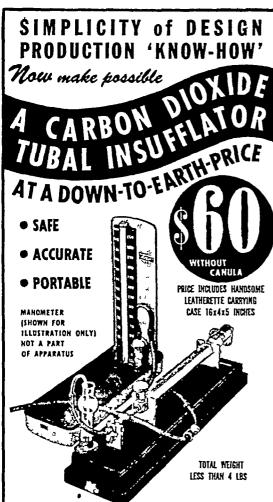
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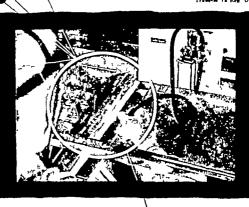
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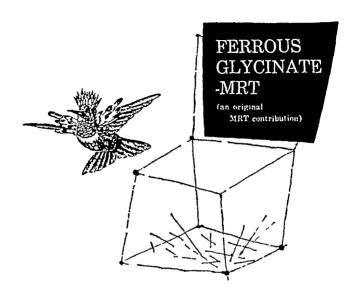
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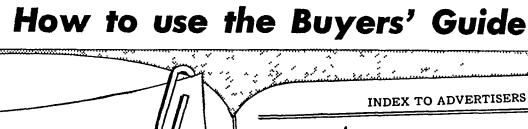
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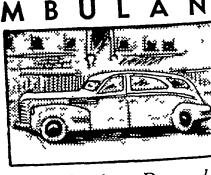
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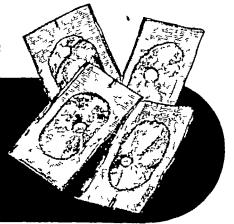
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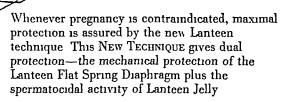




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Arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York

> O W H Mitchell, M D, Chairman George Baehr, M.D., New York Charles D Post, M.D., Syracuse, Presiding

PART I **NUTRITION***

9:30 A M

Some Newer Aspects of Protein Utilizatıon David Schwimmer, M D, Associate

Visiting Physician, Metropolitan Hospital, Associate in Research, New York Medical College, Flower and Fifth Avenue Hospitals, New York Thomas H McGavack, M D, Pro-fessor of Clinical Medicine, New York

Medical College, Flower and Fifth Avenue Hospitals, New York The Influence of Disease on Nutritional Requirements Herbert Pollack, M D, Associate Physician and Chief of Metabolic Division, Mt Sinai Hospital, New

York John Bookman, M.D., Assistant Resident for Metabolic Diseases, Mt Sinai Hospital, New York

PART II
REHABILITATION and PHYSICAL
MEDICINE*

Dynamic Therapeutics in Chronic Disease, with a Clinical Demonstration Howard A Rusk, M D, Professor of Rehabilitation and Physical Medicine, New York University College of Medi-cine, Associate Editor, New York Times, New York

PART III PANEL DISCUSSION MODERN TRENDS IN MEDICAL CARE

Louis H Bauer, M D, Presiding, President,

F C Routley, MD, General Secretary, Canadian Medical Association, Toronto George F Lull, MD, Secretary and General Manager, American Medical Association, Chicago

Medical Society of the State of New York

PART IV ROUND TABLE CONFERENCE ON MEDICAL CARE INSURANCE IN NEW YORK STATE

A. H. Aaron, M.D., Buffalo, Presiding, Chairman, Subcommittee on Medical Expense Insurance of the Council Committee on Economics

- Benefits Offered by Voluntary Non-profit Medical Care Insurance Plans in New York State
 Carlton E Wertz, M D , President,
 Western New York Plan, Inc , Buffalo
- Advantages of a Service Contract for Low Income Subscribers Milton J Goodfriend, M D, Board of Directors, United Medical Service, New York
- Progress Report on Voluntary Non-profit Medical Care Insurance Plans in New York State
 George P Farrell, Director, Bureau
 of Medical Care Insurance, Medical Society of the State of New York
- Home-Town Medical Care of Veterans under Veterans Medical Service Plan of New York, Inc Herbert H Bauckus, M D, Buffalo, President, Veterans Medical Serv-ice Plan of New York, Inc

*Each Lecture Will Be Approximately Thirty Minutes Followed By General Discussion *These lectures are presented by the Medical Society of the State of New York with the cooperation of the New York State Department of Health.



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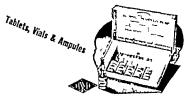
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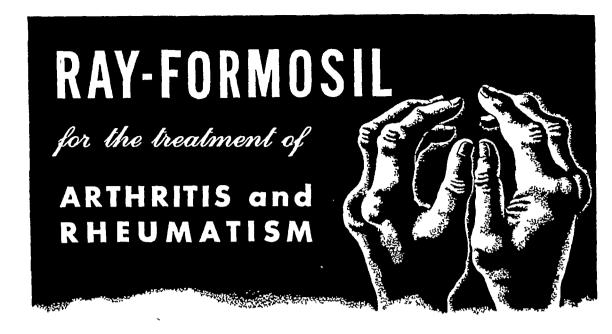
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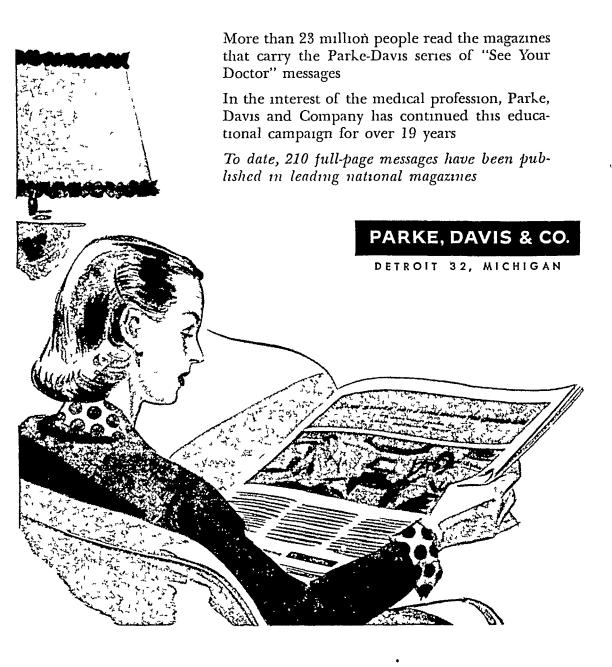
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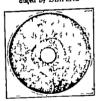


The treatment of ammonia dermatitis (diaper rash) heretofore has been a bothersome and unavailing routine of boric acid rinses and rapid change of soiled diapers.

Usually the results have been unsatisfactory - even with the use of bichloride of mer cury because of the risk of mercuric poisoning. The high incidence of diaper rash therefore emphasizes the need for a more advanced therapy

Cooke¹ demonstrated that the cause of diaper rash is ammonia liberated in the wer disper by bacterial decomposition of urinary urea. The odor of ammonla is readily detected in dispers wet with urine.

Figure 1 - DARK ZONE OF INHIBITION PTO duced by DIAPENE



Bacillus Isolated from B.G.

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IMPORTANT -DIAPENE 15 as basically neces sary as baby oil, powder or ointment, because chafing prickly heat, allergy rashes, etc., are PENE IS a prophylactic MUST for every baby!

REFERENCES

- 1. Cooke, J V Brennemann Practice of Pediatrics 4 Chapeer 41 1945
- 712. Bemon, R. A., et al. J. Ped. 31: Oct., 1947 3 Sallivan, N : Inc'l. Congress of Ped., Mt. Sinal Hospital, New

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DIAPENE — impregnated into the laundered diaper merely by rinsing - inhibits and destroys growth of the saprophytic gram positive bacillus responsible for the ammonia production. DIA PENE, therefore prevents and relieves disper rash by eliminating the cause With elimination of the cause of ammonia dermatitis the eruption - whether crythematus or papulovesicular-



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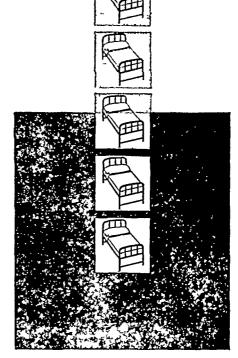
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1. Pierce, R. R.: Am. J Obst. & Gynce. vol. 55 (Feb.) 1948. *Exclusive trademark. © Schenley Laboratories, Inc.

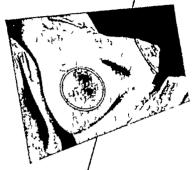


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NEW YORK STATE JOURNAL OF MEDICINE

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Editorials

The Annual Meeting, 1948

It is time now to plan to attend the Annual Meeting of the Medical Society of the State of New York, to be held this year at the Hotel Pennsylvania, May 17 to 21, in New York City

Again let us urge you to reserve hotel accommodations early if you have not already done so The winter having done its worst, it is highly probable that by the time of the meeting the weather will be such as to make driving attractive again for those who will come by automobile

It is yet too early to announce with certainty the principal speakers at the annual banquet, which will be held on Wednesday might, May 19, but we feel sure that you will want to hear them, whoever they are.

The chairmen of the Scientific Program and of the Scientific Exhibits have worked hard and productively to make this year's meeting of more than usual interest. More applications for the scientific exhibit space have this year been received than could be filled, even with a better arrangement of floor space than was possible in 1946.

The Teaching Day Programs of the Council Committee on Public Health and Education will fill the entire day of Tuesday, May

18, and promise to be of extraordinary interest, we are informed. In addition, the section on Radiology will again conduct its film reading session on the basis of submitted roentgenograms. We are informed that the section on Industrial Medicine and Surgery will include a symposium on Hand Surgery with a number of papers to be read by invitation that are of more than usual interest.

We hope that the Annual Meeting of 1948 will be better attended than any previous meeting of the Society The House of Delegates will commence its sessions on Monday morning, May 17 The complex structure of our modern civilization is enveloping the practice of medicine, our system of medical education, the research groups, clinics, and hospitals in a vast web of changing laws, attempts to break down standards of licensure and practice, and to impose government control upon the profession

Medicine must preserve its fluidity, it must be able to adapt itself functionally to the real, the demonstrable needs of a changing economy, a changing social structure, and to make its own constantly improved technology and practice readily available to the sick. It must be jealous of its own independence of thought and action but without

arrogance, it must remain free from the clutching claws of a ruthless and stultifying bureaucracy, it must scrutinize closely all proposals for change to be sure that such are practical and not merely apparently so

These are some of the functions of the House of Delegates which are frequently lost sight of In addition, the House must consider well the qualifications of those whom it elevates to positions of leadership in the

medical profession of the State, the officers of the Society, the delegates to the American Medical Association, those who must make the democratic representative system work

All who can possibly do so are urged to attend this year. The Convention Committee has labored long and hard to make this the best meeting ever held in the State Come yourself and bring your colleagues with you.

Socialism and Medicine in Great Britain

On July 5, 1948, the National Health Services Act will go into effect in Great Britain. The Act will be, when it becomes operative, another step in the nationalization program of the Labor Government Under it any resident of Great Britain will be entitled to medical care, hospital care, drugs, home nursing, appliances, and limited dental service, regardless of income. All this will be paid for—partly by contributions to the social insurance fund, partly by taxation.

There is said to be free choice of physician under the Act, "but physicians may or may not enter the public service. Hospitals are nationalized but administered by local and regional committees. Health centers are to be established, and, in these, general practitioners will have their offices, so that they may practice ultimately in groups which will have every diagnostic and therapeutic facility at their disposal."

Few things are either as good as they look or as bad as they seem In Great Britain the National Health Services Act is the legislative product of a Labor Government duly elected and placed in power by the free voters of the country It was known to all that such a Government proposed, if elected, to carry out a program of nationalization, and that medical services would be included in such a program. There is in Great Britain, therefore, a certain validity in the establishment of the Act which flows from the obvious desire of the people to install and maintain a socialist regime for Under the circumstances better or worse

1 New York Times (Jan. 12) 1948 p. 18

the scheme may work since the people want it, seem to be willing to pay for it and to put up with the consequences

Preceded by war, accompanied by grinding national debt, and followed by strife between the ministry of health and the medical profession, the implementation of the Act by the establishment of rules and regulations seems to be somewhat retarded—not an altogether auspicious beginning, but one to be observed with scientific detachment

To doctors here, who have followed the program for Great Britain outlined in 1944 by the Conservatives and, subsequently, as to medical reform, amplified and enacted by the Labor Government, it will be of interest to observe the process of changeover and adjustment from private to public The shift from conservatism and free enterprise to socialism and statecontrolled management of national resources, among them medicine, is a function of poverty Call it reform or label it any way you please, it is still as simple as that Confiscatory taxation is a prelude, usually over a period of time, following the Keynesian philosophy that private thrift and saving are to be discouraged and public spending encouraged Since public spending involves increasing government control of the projects on which public moneys are to be spent, the power of the purse will eventually exert itself through rules and regulations having the force and effect of

In Great Britain the rules and regulations which will govern are now in process of being

formulated to take effect in July of this year. In its present form, says the British Medical Journal "the Act is the first and irrevocable step towards a whole-time State Medical Service (not a 'Health' Service)'".

1 (Jan. 17) 1948 p. 104

Be it noted that the dictatorship of the State represented by the current Labor Government is the result of popular acceptance of such a philosophy and that all will have to adjust to it in the end—or change it

Health Is the People's Job

An advance release from the Federal Security Agency, Mr O A. Ewing, administrator, gives notice of a National Health Assembly to meet in Washington, May I to 4 of this year, to "help develop a ten-year health program for (the) nation" Twenty-four national leaders in various fields are invited to serve on the conference executive committee, which will consist of representatives of public and private organizations and agencies in the country concerned with various phases of the nation's health

The conference to be called by the FS A. administrator is in response to a letter² from the President to Mr Ewing requesting him "to undertake a comprehensive study of the possibilities for raising health levels and to report upon feasible goals, which might be realized by the American people in the next decade "

Mr Ewing hopes that what comes out of the Assembly should have immediate benefits

- A guide to community action for local health improvements.
- 2 A detailed, practical pattern of cooperation among all organisations operating in the health field—public and private, national, state, and local
- 3 A more detailed and specific knowledge of our present health picture and of the job that has to be done to improve it.

Among the twenty four members of the Executive Committee as of February 13, 1948, we find

Doctors of Medicine, 1, Dr George F Lull, secretary, A M A Others , 23, individuals or organization representatives.

Public Health Doctors, 0, A.P.H.A., N.T.A., U.S.P.H.S., etc

The representation on the Executive Committee of national health organizations and doctors of medicine is so strikingly absent that one is immediately impelled to ask, are not doctors people? Are not those who might represent the A.P.H.A., and the N.T.A., for instance, considered by the F.S.A. administrator to be competently interested in health as the people's job?

Mr Ewing says in the release

In the final analysis, health is the people's job We can have national interest and action only to the extent that we have community interest and action.

So the job, as I see it, is this to see what we have—to know accurately the health facilities and personnel of the nation and of each community, to determine what we need, the difference between the two will show us our health deficits, and to devise feasible methods of meeting these deficits

In the light of these declared objectives we are somewhat at a loss to understand why those who might contribute to such a conference expert knowledge of and long experience in health matters should be so conspicuously omitted to date

We agree that "in the final analysis, health is the people's job" and that as the administrator says rightfully, "We can have national interest and action only to the extent that we have community interest and action" We believe that community interest and action would be accelerated rather than retarded if the people of the communities were assured that the panel dis-

Feb. 15 1918.

cussions of the Executive Committee included representatives of the APHA, the NTA, and the USPHS, to cite a

few of those who assist expertly in the creation and maintenance of health in the far-flung communities of the nation

Current Editorial Comment

A New Surgeon General The United States Public Health Service is a Federal agency with which the medical profession of the country comes into more or less contact, both directly and indirectly directing head is an important person, medically and administratively The new appointee, Dr Leonard A Scheele, is a career man who has occupied many important positions in the service to which he was first commissioned as a quarantine officer for San Francisco in 1934, soon after his graduation as an MD from Wayne University in Detroit Since then he has been identified with various public health movements, including the National Cancer Control program

From 1943 to 1945 he was assigned to the Army in various capacities and served in the European theater during World War II For his outstanding achievements he received the American Typhus Medal, the Legion of Merit, and several foreign decorations. He holds membership in various medical societies, including the American Medical Association.

Dr Scheele occupies a very responsible position. He should be known and make himself known to the medical profession. His attitude toward its problems will be awaited with interest by the profession, particularly with respect to the socialization of medicine.

Our best wishes are extended to him for a successful career in his present office

Waste The Associated Press¹ reports the National Safety Council as authority for the depressing toll of deaths from accidents in 1947 100,000 killed, 10,500,000 injured, economic loss \$6,700,000 Of the injured, 1,100,000 were hurt in traffic accidents

Home accidents caused 33,500 deaths, which is said to be an increase of 3 per cent over 1946, other accidents included 17,000 civilian occupational, 19,000 public occupational, and 1,600 military deaths

Apparently one out of every 14 persons in the country suffered a disabling injury in

¹ Feb 6 1948.

1947 These appalling statistics of the frightful wastage of human resources in this country make the blood run cold slaughtered 100,000 persons—accidentally of course, but conclusively for all that—in three hundred sixty-five days of last year These who die are, or were, people, human beings, not just statistics to be entered casually in the pages of our history ten million who were maimed or broken in one way or another—accidentally of course, but painfully for all that—at the moderate cost of some \$6,700,000, are not lay figures or mannequins, temporarily dismembered in some show window for the convenience of the model dresser, but real flesh and blood people, citizen taxpayers, voters perhaps, or commuters, workers in the humdrum toil of the world, endowed with life and hope, now, suddenly, in 1947—accidentally of course— 10,500,000 of them are converted into numbers of maimed by the fairy wand of the so modern, well-designed, and electrically operated statistical machines

On August 6, 1945, an atomic bomb dropped on Hiroshima and, exploding with a force equivalent to 20,000 tons of TNT, obliterated 60 per cent of that city of 343,000 inhabitants "destroying nearly every living thing" Scientists afterwards urged that the people of the United States with other peoples must effectively control atomic power They "must not fail The alternatives lead to world suicide," said the scientists 2

Do we have to use atomic power and weapons to get rid of everybody? We do not presume to know, but two years after Hiroshima, right here in the US, at a cost of only a measly \$6,700,000 as against the \$2,000,000,000 it cost to develop the atomic bombs, we did quite well with the old standard tools carelessness, negligence, the automobile, the airplane, and the good old reliable dangerous house, 100,000 were killed, 10,500,000 were maimed Apparently all we need is the time. At the current rate, in ten years—well, figure it out yourselves

² World Almanae, 1946 p 93

1948 Annual Meeting

Medical Society of the State of New York

May 17 to 21-Hotel Pennsylvania, New York City

House of Delegates

The regular annual meeting of the House of Delegates of the Medical Society of the State of New York will be called to order at 10 00 a m on Monday, May 17, 1948, in the Salle Moderne, 18th floor of the Hotel Pennsylvania, New York City

In accordance with Chapter II, Section 3 of the revised Bylaws, the House will assemble according to the following schedule Monday, May 17, 1948, 10 00 A M

Tuesday, May 18, 1948, 9 00 AM and 2 00 P.M.

Wednesday, May 19, 1948, 9 00 AM

At the last adjourned session (9 00 A M., Wednesday, May 19) the election of officers, councilors, trustees, and delegates will occur in accordance with Chapter III, Section 1 of the revised Bylaws.

Albert F R. Andresen, M D, Spealer W P Anderton, M D, Secretary

Annual Meeting

The Annual Meeting of the Medical Society of the State of New York will be held on Wednesday, May 19, at 7 00 PM. on the Penn Top, Hotel Pennsylvania, New York City

W P ANDERTON, M.D., Secretary

Registration

Registration for delegates will be held in the foyer of the Salle Moderne, 18th floor of the Hotel Pennsylvania, on Monday, May 17, after 9 00 A M, for members and guests on the ballroom floor, on Monday, Tuesday, Wednesday, and Thursday, May 17 to 20, from 9 00 A M to 6 00 P M, and on Friday, May 21, from 9 00 A.M. to 2 00 P M

Exhibits

Scientific Exhibits will be located on the ballroom floor, the ballroom balcony and the lobby mezzanine

Technical Exhibits will be located on the ballroom floor

Scientific Motion Pictures will be show in Parlor C

Teaching Day

A special series of lectures, arranged be the Council Committee on Public Health and Education of the Medical Society of the State of New York, will be held Tuesday May 18, at 0 30 A M and 2 00 P.M. in the Keystone Room

Scientific Sessions

General Sessions will be held on Wednes day and Friday afternoons Section and Session Meetings will be held on Wednesday morning, Thursday morning and afternoon and Friday morning and afternoon

142nd Annual Meeting

The Penn Top, Wednesday, May 19 7 00 PM

Calling the Society to order by the President, Louis H. Bauer, M.D.

Reading of the Minutes of the 141s Annual Meeting by the Secretary, W P Anderton, M.D

The Annual Banquet

The Annual Banquet will be held or the Penn Top, Wednesday, May 19, at 7 00 P.M. guest speakers to be announced.

Tickets will be available at the registration deak on the ballroom floor, and at the Woman's Auxiliary Registration Desk-Penn Top foyer

The Woman's Auxiliary

See page 791 for the program

DO YOU HAVE YOUR HOTEL RESERVATION FOR THE ANNUAL MEETING?

If you do not now have a confirmed hotel reservation in New York City for the Annual Meeting of the Medical Society of the State of New York, May 16 to 21, 1948, at the Hotel Pennsylvania, please fill out and mail the reservation form at the bottom of this page, and send it directly to the Hotel Pennsylvania

Should your reservation be received after the six hundred rooms set aside for the Society at the Hotel Pennsylvania have been assigned, your reservation will be turned over to one of the neighboring hotels—the Hotel New Yorker, the Governor Clinton Hotel, the Hotel McAlpin, the Hotel Martinique Please indicate your preference on the reservation blank Confirmation of your reservation will come to you direct from the hotel making the accommodation

If you do not use the reservation form below, be sure to identify yourself as a physician when writing regarding reservations. This will insure proper attention to your request

W P ANDERTON, M D, Secretary

Mr James H McCabe, Manager Hotel Pennsylvania New York 1, New York			— — 	•	
Dear Mr McCabe					
Please reserve accommodations as checked (\checkmark)	below				
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More Than Two Persons in One Room F Twin-Bed Room, the extra charge is \$2 00 per o		dditional	person	ın Doub	le- or
If a room at the rate requested is unavailab	le reserva	tion will	be mad	e at the	next
available rate					

SCIENTIFIC PROGRAM

Duncan W Clark, M.D., Chairman, Brooklyn

and

Chairmen of Sections and Sessions

GENERAL SESSIONS

Dr Clark, Presiding

The presentations at these Sessions will consist of one-half hour lectures, without discussion — The meetings will start promptly at the hour specified Members are requested to be in their seats at least five minutes in advance of the meeting time

Wednesday, May 19-2:30 P.M.

Hotel Pennsylvania, Keystone Room

- i Title to be Announced
 Alexander Brunschwig, M.D Attending
 Surgeon, Memorial Hospital New York
- 2. THE ROLE AND CONTROL OF RENAL DYSPUNCTION IN CONDENTIVE HEART FALURE
 Louis Leiter, M.D., Ph.D., Chief of Medical
 Division Montefiore Hospital, Clinical
 Professor of Medicine, College of Physicians
 and Surgeons Columbia University New
 York
- 3 FETAL DEFECTS RESULTING FROM ILLNESSES OF THE PREGNANT MOTHER SPECIAL REFERENCE TO VIRUS DISEASES
 - Murray H. Bass, M.D., Associate Clinical Professor of Pediatrics College of Physicians and Surgeons, Columbia University, Consulting Pediatrician, Mt. Sinal Hospital, New York
- 4 NEWER ASPECTS OF CLINICAL ELECTROCARDI
 OGRAPHY

Richard S Gubner M D, Associate in Medicine Long Island College of Medicine Assistant Medical Director Equitable Life Assurance Society of the United States Brooklyn H. E Ungerteider M D, Medical Research Department, Equitable Life Assurance Society of the United States, New York

Friday, May 21-2 00 P.M.

Hotel Pennsylvania Keystone Room

- DISTRIBUTION OF POLICEMENTIS VIRUS IN THE COMMUNITY
 - Thomas Francis, Jr M.D., School of Public Health, University of Michigan, Ann Arbor Michigan (By invitation)
- 2 Some Recent Contributions of Physical Medicine in Policontelling
 - Arthur L. Watkins, M.D., Chief of Physical Medicine Massachusetts General Hospital, Massachusetts (By invitation)
- 3 Hypertension A Manifestation of Hypertensive Vascular Disease
 - George A. Perera, M.D., Assistant Professor of Medicine College of Physicians and Sur geons Columbia University New York
- 4. SIGNIVICANCE OF CHOLESTEROL IN CORONARY ARTERIOSCIEROSIS*
 - Alfred Steiner, M.D., Assistant Attending Physician, Columbia Research Service, Goldwater Memorial Hospital Instructor in Medicine College of Physicians and Sur geons Columbia University New York

*The A. Walter Suiter Lectureship This will be the ninth lecture to be delivered under this lectureship fund.

SECTIONS

All papers read before the Society by members become the property of the Society 'The *original* copy of each paper shall be left with the Secretary of the Section

Discussers should have their remarks typed, double-spaced, and should hand them to the Secretary

Time limits Twenty minutes for each paper, five minutes for individual discussion

Section meetings shall begin promptly at the hour specified. The first order of business of the first session of the second day of Section Meetings shall be the election of officers "To participate in the election of any Section, a member must be registered with such Section and must have recorded his name and address in the Section registry"—Bylaws, Chapter XII, Section 3

Section on ANESTHESIOLOGY

Chairman
Vice-Chairman
Secretary

Rose M Lenahan, M.D., Buffalo
Harold F Bishop, M.D., Valhalla
Paul M Wood, M D., New York

Wednesday, May 19—10 00 A M Hotel Pennsylvania, Headquarters Room

1 SPHENOPALATINE BLOCK FOR THE RELIEF OF MUSCULAR SPASM AND PAIN (WITH SPECIAL REFERENCE TO LUMBOSACRAL PAIN)

J Lewis Amster, M D, Bronx
Discussion Simon L Ruskin, M D, New
York, Julius Neuberger, M D, New York

2 EXTENSION OF PULMONARY TUBERCULOSIS FOLLOWING THORACIC OPERATIONS AND ANESTHESIA

Harold F Bishop, M D, Valhalla
William Parke, Jr, M D, Valhalla (By invitation)
Discussion Edward Loftus, M D, Valhalla
(By invitation)

3 Use of Pitressin in Prolonging Spinal Anesthesia with Procaine

Oscar Stover, M D, Buffalo Discussion John H Geckler, M D, Buffalo

4 ESOPHAGEAL INTUBATION FOR REPAIR OF PHARYNGO-ESOPHAGEAL DIVERTICULA RICHARD N Terry, M D, Buffalo Discussion J Sutton Regan, M D, Buffalo

5 RECENT STUDIES ON THE ANALGESIC ACTION OF LOCAL ANESTHETIC DRUGS
EMERY A. Rovenstine, M D, New York
E M Papper, M D, Flushing

Discussion Solomon G Hershey, M D , New York

Thursday, May 20—2 00 P M
Hotel Pennsylvania, Headquarters Room
Intravenous Anesthesia
Paul Searles, M D , Buffalo

Paul Searles, M. D., Buffalo Rose M. Lenahan, M. D., Buffalo Discussion Samuel L. Lieberman, M. D., Buffalo

2 HISTORICAL OBSERVATIONS ON INTERCOSTAL PARALYSIS UNDER ANESTHESIA George Burford, M D, New York

- 3 Indications for Music in Anesthesia Irving Pallin, M D , Brooklyn Albert E Chiron, M D , Bronx Discussion Paul Wood, M D , New York
- 4 Pulmonary Pathology as Related to Infant Resuscitation
 Benjamin Etsten, M.D., Albany
 William Schwab, M.D., Albany (By invita-

tion)

Discussion Harry D Eastman, M D, Albany
Intravenous Procaine in the Management
of the Injured Hand

OF THE INJURED HAND
David J. Graubard, M. D., New York
Milton H. Waldman, M. D., New York
Milton C. Peterson, M. D., Kansas City,
Missouri (By invitation)
Discussion, Honory H. Butter, M. D., New York

Discussion Henry H Ritter, M D, New York

Section on DERMATOLOGY AND SYPHILOLOGY

 $\begin{array}{ll} {\rm Chairman} & {\rm Maurice} \; {\rm J} \; \; {\rm Costello,} \; {\rm M} \; {\rm D} \; , \; {\rm New} \; {\rm York} \\ {\rm Secretary} & {\rm William} \; {\rm F} \; \; {\rm Hoover}, \; {\rm M.D} \; , \; {\rm Jamestown} \end{array}$

Thursday, May 20—9 00 A.M Hotel Pennsylvania, Penn Top South

- 1 INTERSTITIAL KERATITIS
 Thomas N Graham, M D, New York
 Hunter H Romaine, M D, New York
- 2 ERYTHEMA MULTIFORME OBSERVATIONS ON 100 PATIENTS ON THE DERMATOLOGIC WARDS AT BELLEVUE HOSPITAL, 1936–1947

 Maurice J Costello, M D, New York Jules E Vandow, M D, New York Discussion Frank C Combes, M D, New
- 3 A CASE OF YAWS IN NEW YORK CITY
 Charles F Post, M D, New York
 Charles Sheard, Jr, M D, New York (By
 invitation)

York

Discussion Howard Fox, M D, New York

4 A STUDY OF POSITIVE SEROLOGIC TESTS IN
NONSYPHILITIC INFANTS OF TREATED MOTHERS
Dabney Moon-Adams, M D, New York
Discussion Thurman B Givan, M D, Brooklyn

3

THE USE OF PLACEBOS IN THE LOCAL THERAPY OF SKIN DIBEASES

E. William Abramowitz, M.D., New York Discussion Joseph L. Morse M.D. New York

REMOVAL OF TATTOO MARKS Charles Lerner, M D., New York Discussion Louis Tulipan M D New York

Friday, May 21—9 00 A.M Hotel Pennsylvania, Salle Moderne

PORORERATOSIS OF MIRELLI Leslie Paxton Barker, M.D., New York Rarl S Hallinger, Jr., M.D., New York William Huber, M.D., New York (By invitation)

Discussion David Bloom M.D New York

2. THE TEETH AND SKIN DISEASES George C. Andrews, M.D., New York
Anthony N Domonkos, M D New York
Discussion Eugene F Traub M.D., New York

8. PIGMENTED BASAL CELL EPITHELIONA Anthony C Cipollaro, M.D., New York Wilbert Sachs M.D., New York Adrian Brodey, M.D., Woodmare Discussion Gerald F Machacek, M.D. New York

STREPTOMYCIN IN DERMATOLOGY ITS VALUE AND LIMITATIONS Frank C. Combes M D., New York Orlando Canizares, M D., New York Harry Shatin, M D., New York Carl Kaufman, M D., New York (By invi

tation) Discussion Jack Wolf M D New York

 CONTACT DERMATITIS FROM BEETLES RE-FORT OF A CASE DUE TO THE CARPET BEETLE (Anthremus Scrophulariae) Frank E. Cormia, M.D., New York George M Lewis, M.D., New York

THE PERMANENT CAMOUFLAGE OF PORT WINE STAINS OF THE FACE BY INJECTION OF INSOL-UBLE PIGMENTS (TATTOOING)
Herbert Conway M.D., New York
Discussion Samuel M Peck, M D New York

Section on GASTROENTEROLOGY AND PROCTOLOGY

Chairman Harry L. Reynolds M.D., Schenectady Vice-Chairman

Rudolph V Gorsch, M D New York Secretary Frank Meyers, M.D Buffalo

Wednesday, May 19—10 00 A.M Hotel Pennsylvania Parlor 1

PILONIDAL SINUS A STANDARDINED TREAT JOHN C M Brust M.D., Syracuso
Joseph Sarner M.D., Philadelphia Pennsylvania (By invitation)
Discussion F F McGauley M.D. Schencetady

TROPICAL DISEASES OF GASTROINTESTINAL TRACT IN VETERANS Howard B. Shookhoff, M.D., New York Discussion Z T Bercovitx, M.D., New York

ANAL TUBERCULOSIS Lester S. Kuspp, M. D., Buffalo uscussion A. W. Martin Marino M. D. Discussion A. Brooklyn

POLYPS OF THE COLON
George E. Binkley, M.D., New York
Discussion Chas. Gordon Heyd, M.D. Now York

Thursday, May 20-2 00 P M Hotel Pennsylvania Parlor 1

DIAGNOSIS AND MANAGEMENT OF THE POST-CHOLECUSTECTOMY SYNDROME J Russell Twiss, M.D. Now York
R. Franklin Carter, M.D., Now York
Discussion David P. Boyd M.D. Boston

Massachusetts

THE ROLE OF THE VAGUE NERVES IN THE MEDICAL AND SURGICAL THERAPY OF PER-TIC ULCUR Asher Winkelstein, M.D., New York Discussion Harry L. Segal, M.D., Rochester

ACUTE PANCHEATITIS Henry L. Bockus, M D , Philadelphia, Penn sylvania (By invitation) Edward C. Raffensperger, M.D., Philadelphia Pennsylvania (By invitation)

Discussion A. H. Aaron, M.D. Buffalo PANOREATIC SURGERY William B Parsons, M.D., New York Discussion Frank Glenn M D New York

Section on INDUSTRIAL MEDICINE AND SURGERY

Chairman Harry V N Spaulding, M.D New York Secretary Christopher Stahler Jr M.D Albany

> Wednesday, May 19-10 00 A.M Hotel Pennsylvania, Penn Top

> > Sumposium HAND SURGERY

TENDON TRANSFERS IN THE HAND AND FORE ARM Sterling Bunnell M.D San Francisco California (By invitation) Condict W Cutler Jr Discussion New York

FLEXOR TENDON REPAIR BY FREE GRAPTING Ronald Furlong, F.R.C.S., London, England (By invitation)

Discussion Philip Wilson M.D New York

RECONSTRUCTION OF A THUMB Walter C. Graham, M.D., Santa Barbara, California (By Invitation)
Discussion J William Littler M.D Now York (By invitation)

> Thursday May 20-2 00 P M Hotel Pennsylvania, Penn Top Round Table Conference

THE PNEUMOCONIOSES

INDUSTRIAL ASPECTS Leonard Greenburg M.D., New York

- Morphologic Aspects Arthur Vorwald, M D, Saranac Lake
- DIAGNOSTIC ASPECTS

Edgar Mayer, M.D., New York

- EVOLUTION AND CLINICAL COURSE J Burns Amberson, M D, New York
- DISABILITY GRADING AND FUNCTIONAL DIS-ABILITY STUDIES George Wright, M D, Saranac Lake
- Compensation Aspects Mary Donlon, LL D, New York (By invita-

Section on MEDICINE

George E Anderson, M D, Brooklyn Chairman Vice-Chairman Grosvenor W Bissell, M.D., Buffalo Thomas H. McGavack, M.D., New York

Secretary Thursday, May 20-10 00 A M Hotel Pennsylvania, Keystone Room

Joint Meeting with the Section on Surgery (See Section on Surgery)

Friday, May 21—10 00 A M Hotel Pennsylvania, Penn Top South

- ROLE OF ANTICOAGULANTS IN THE TREATMENT OF HEART DISEASES Irving S Wright, M D, New York
 Discussion Edwin P Maynard, Jr, M D,
 Brooklyn, Harold F R. Brown, M D, Buffalo
- RICKETTSIALPOX Harry M Rose, M D, New York Discussion John K Miller, M D, Albany
- (By invitation) STREPTOMYCIN IN TUBERCULOSIS Experi-MENTAL OBSERVATIONS ON EFFICACY AND LIMI-RATIONS

William H Feldman, MD, Rochester, Minnesota (By myitation) Discussion Howard G Dayman, M D, Raybrook, Susan J Hadley, M D, New York

(By invitation) EVALUATION OF THE PRESENT STATUS OF ANTI-HISTAMINE SUBSTANCES

Will Cook Spain, M D, New York Discussion George F Koepf, M D, Buffalo

Section on NEUROLOGY AND PSYCHIATRY

Chairman Burton M Shinners, M D, Buffalo Abraham M Rabiner, M D, Brooklyn Secretary

> Thursday, May 20-10 00 A M Hotel Pennsylvania, Parlor 1

CONGENITAL ANOMALIES AS A PROBLEM IN NEUROSURGERY

William F Beswick, M D, Buffalo Discussion John E Scarff, M D, New York

FUNCTION OF A CHILD GUIDANCE CLINIC IN A CHILDREN'S HOSPITAL

Sherman Little, M.D., Buffalo Discussion Harry Bakwin, M.D., New York

PRACTICAL ASPECTS OF CERFBRAL VASCULAR ACCIDENTS

H Houston Merritt, M D, Brony Discussion Paul Garvey, M.D., Rochester

THE OUTLOOK FOR PATIENTS ADMITTED TO A MENTAL HOSPITAL AFTER THE AGF OF SIXTY Hollis E Clow, M D, White Plains Discussion George Kirby Collier, M D, Rochester

Friday, May 21—10 00 A M Hotel Pennsylvania, Parlor 1

- ELECTRONARCOSIS IN PSYCHIATRIC THERAPY Bernard L Pacella, M D, New York George M Masotti, M D, Buffalo
- CLINICAL ASPECTS OF NEUROLOGIC TEACHING Wardner D Ayer, M D, Syracuse Discussion I S Wechsler, M D, New York
- PROBLEM OF THE SCALENE ANTICUS SYNDROME Bernard D Judovich, M D, Philadelphia, Pennsylvania (By invitation) Discussion Theodore von Storch, M.D., Albany
- SPINAL EPIDURAL INFECTION RESULTS SINCE ADVENT OF ANTIBIOTICS AND CHEMOTHERAPY M Frank Turney, M D, Brooklyn E Jefferson Browder, M D, Brooklyn Discussion Wallace B Hamby, M D, Buffalo

Section on OBSTETRICS AND GYNECOLOGY

Chairman William M Mallia, M.D., Schenectady Vice-Chairman

J Thornton Wallace, M.D. Brooklyn

Wednesday, May 19-10 00 A.M Hotel Pennsylvania, Keystone Room

HABITUAL ABORTION Carl T Javert, M D, New York
Discussion Edward C Hughes, M D, Syracuse, William F Finn, M D, New York

COMPLETE PROLAPSE FOLLOWING HYSTEREC-

TOMY Mortimer N Hyams, M D, New York Discussion John H. Cornell, M D, Schenectady, John G Hayes, M D, Albany

THE FEMALE PERINEUM ITS STRUCTURE, FUNCTION, AND PRESERVATION Raymond J Pieri, M D, Syracuse
Frank C Meyer, M D, Syracuse
Discussion Wendell George, M D, Watertown, Raymond L Rhodes, M.D, Glens Falls

> Thursday, May 20—2 00 P M Hotel Pennsylvania, Keystone Room

- SPINAL ANALGESIA AND ANESTHESIA IN OB-STETRICS
 - H. Arthur Snell, M D, Schenectady
 Discussion Edward G Waters, M D, Jersey
 City, New Jersey (By invitation), William J
 Gleeson, M D, Jersey City, New Jersey (By invitation)
- CONSIDERATION OF SOME OF THE PROBLEMS ASSOCIATED WITH PROLONGED LABOR Duncan E Reid, MD, Boston, Massachu-

setts (By invitation) Discussion Robert G Douglas, M.D., New York, Charles J Marshall, M.D., Binghamton 3 THE USE OF THE RECOVERY ROOM IN LOWERING THE MATERIAL DEATH RATE FROM POST PARTUM HEMOORHAGE LOWIS F. MCLEAR, M.D., BUIGIO

Lewis F McLean, M.D., Buffalo Discussion Hugh McDowell M D Buffalo, Charles A Gordon, M D Brooklyn

Section on OPHTHALMOLOGY AND OTOLARYN GOLOGY

Chairman Thomas H Johnson, M.D., New York Secretary Darrell G Voorhoos, M D New York

Thursday, May 20—10 00 A.M Hotel Pennsylvania, Manhattan Room East

1 THE PATHOLOGIC BASIS OF SOME COMPLICA TIONS OF OGGLAR SURGERY Albert G Snell, Jr., M.D., Rochester Discussion Searle B Marlow M D Syracuse

2 Some Associated Eye and Skin Manifesta tions in Statumic Direase

Isadore Givner, M.D., New York
Discussion Marion B Sulsberger M D New

York

New Wats of Influencing the Intraocular
Tension

F W Stocker, M.D., Durham North Carolina (By invitation)
Discussion Richard Townley Paton M.D
New York

4. BLOOD PREASURE REACTIONS OF PATIENTS UNDERGOING EYE OPERATIONS UNDER LOCAL AMERITESIA

W Guernsey Frey, M D., New York Discussion George Edgar Burford, M.D Now York

Friday May 21—10 00 A.M. Hotel Pennsylvania, Manhattan Room East

1. BACKEROPHAGE AND AUTOGENOUS VACCINES IN THE TRATEENT OF CHRONIC SINUS DISEASE AND OTHER RESPIRATORY APPECTIONS
Hugh M Kinghorn, M.D. Sarango Lake Discussion F Howard Westcott, M D New York Edmonde D Neer M D New York

2 PRESENT STATUS OF THE FENESTRATION OF-ERATION
J Morrisset Smith, M.D., New York
Discussion Robert L Moorhead, M D Brooklyn

3 IRRADIATION OF THE EUSTACHIAN TUDE
Edmund P Fowler, Jr., M.D., New York
Discussion Exnest A. Weymuller M D New
York

4 CONSERVATIVE AND SURGICAL MANAGEMENT OF ETHMOID AND SPIEMOID SITURILIS Stuart L. Craig, M.D., New York Discussion David Robb M.D. Ithaca

Section on ORTHOPEDIC SURGERY

Chairman Secretary David M Bosworth, M D , New York Joseph D Godfroy M.D., Buffalo

Thursday May 20—10:00 A.M Hotel Pennsylvania, Manhattan Room West 1 RECURRENT DISLOCATION OF THE PATELLA END RESULTS FOLLOWING SURGICAL TREAT-MENT

Pio Blanco, M.D., Buffalo Discussion Lewis Clark Wagner M.D., New York

2 ARTHROPLASTIES OF THE HIP AN OBJECTIVE STUDY

Frank B. Stinchfield M.D., New York Robert Carroll, M.D., New York (By invitation)

Discussion Philip Dunces Wilson M.D.

Discussion Philip Duncan Wilson M.D. New York

SUPPLEMENTARY PROTEIN FEEDING FOR AGED AND CHRONICALLY INFECTED ORTHOPEDIC PA-TIENTS

Alfonso Della Pietra, M.D., New York Discussion Aaron Bodansky Ph.D New York (By invitation)

CALCAREOUS BURSITIS

Samuel Kleinberg, M.D., New York
Discussion Leonidas A. Lantzounis M.D.
New York

Friday, May 21—10 00 A.M Hotel Pennsylvania, Manhattan Room West

Joint Meeting with the Section of Orthopedic Surgery of the New York Academy of Medicine Chairman Edgar M Bick, M.D., New York T Campbell Thompson M.D New York

Anterior Displacement of the Sacrum at the Fifth Lumbar Vertebra

Nicholas S Ransohoff, M.D New York Discussion Robert K. Lippmann, M.D New York

DYNAMIC POSTURE

M Beckett Howorth, M.D., New York
Discussion Frederick R. Thompson, M.D.
New York

3 OSTEOCHONDRITIS DISSECANS OF THE TALUS IN RELATION TO RECURRENT ANNEL SPRAINS Frederick M. Marek, M.D., New York Discussion John O McCauley Jr M D New York

4 THE MECHANICS AND PATHOGENESIS OF STRUCTURAL SCOLIOSIS

Alvin M Arkin, M.D., New York
Discussion Mather Cloveland, M.D. New
York

Section on PATHOLOGY AND CLINICAL PATHOLOGY

Chairman Vice-chairman Victor W Borgstrom, M.D. Blinghamton M.J. Fein M.D. New York

Wednesday May 19-10:00 A.M Hotel Pennsylvania Parlor 2

PAPILLARY TUMORS OF THE THYROID GLAND G. H. Klinck, Jr., M.D., Troy Discussion Virginia Kneeland Frantz M.D. New York TUMORS OF THE TESTES Nathan Chandler Foot, M D, New York Discussion Arthur Purdy Stout, M.D., New York

VISCERAL INVOLVEMENT IN MULTIPLE MYE-

Jacob Churg, M D, New York
Alvin J Gordon, M D, New York
Discussion Maurice N Richter, M D, New
York, I Snapper, M D, New York

Thursday, May 20-2 00 P M Hotel Pennsylvania, Parlor 2

GIANT FOLLICLE LYMPHADENOPATHY S E Cohen, M D, Elmira V W Bergstrom, M D, Binghamton Discussion Joseph C Ehrlich, M D, New York, William Harris, M D, New York

PREDICTIONS OF ERYTHROBLASTOSIS IN THE Unborn Child by Antenatal Blood Tests A S Wiener, M D, Brooklyn Discussion Lester J Unger, M D, New York

SURFACE ACTIVE SOLVENTS IN TOPICAL ANTI-

BIOTIC THERAPY Edwin J Grace, M.D., Brooklyn Vernon Bryson, Ph.D., Cold Spring Harbor (By invitation) Discussion Harold A Abramson, M.D., New York

Section on PEDIATRICS

George R. Murphy, M.D., Elmira Chairman Vice-Chairman Caldwell, M.D., New York Jerome Glaser, M.D., Rochester George Secretary

Thursday, May 20—10 00 A.M Hotel Pennsylvania, Parlor 2

RECENT CONTRIBUTIONS TO THE DIAGNOSIS AND TREATMENT OF PERTUSSIS William L Bradford, M D, Rochester Discussion Jerome Kohn, M D, New York

SURGERY IN CHILDREN
Edward J Donovan, M D, New York
Discussion John Aikman, M D, Rochester,
R Franklin Carter, M D, New York

ORTHOPEDIC MANAGEMENT OF FOOT PROBLEMS IN CHILDREN

Fred L Liebolt, M D, New York Discussion Fred W Bush, M D, Rochester 4. REPORT OF STUDY OF CHILD HEALTH SERVICES

George M Wheatley, M.D., New York Discussion Paul W Beaven, M.D., Rochester

Friday, May 21—10 00 A.M Hotel Pennsylvania, Parlor 2

RADIUM THERAPY TO NASOPHARYNX IN ASTH-MATIC CHILDREN Ernest A. Weymuller, M.D., New York Discussion Will Cook Spain, M.D., New York, George R. Brighton, M.D., New York

CARE OF THE NEWBORN
Stewart H Clifford, M D, Boston, Massachusetts (By invitation)
Discussion William J Orr, M D, Buffalo

COMMON ERRORS IN PEDIATRIC PRACTICE Harry Bakwin, M D , New York Discussion John D Craig, M D , New York

Section on PUBLIC HEALTH, HYGIENE, AND SANITATION

Chairman Secretary

Philip J Rafle, M D , New York F E Coughlin, M D , Troy

Wednesday, May 19—10 00 Á.M Hotel Pennsylvania, Manhattan Room West

Symposium Tuberculosis

Modern Approach to Tuberculosis Herman E Hilleboe, M D, Albany

NEW DEVELOPMENTS IN BCG VACCINATION Konrad E Birkhaug, M D, Albany

NEW DEVELOPMENTS IN LABORATORY TECHNICS Bernard Davis, M D, New York (By invitation) Discussion of Symposium Arthur B Robins, M D, New York

Thursday, May 20—2 00 P M Hotel Pennsylvania, Manhattan Room West

Nonspecific Reactions in Serologic Tests FOR SYPHILIS Victor N Tompkins, M D , Albany Discussion William A Brumfield, MD. Albany

CARING FOR THE CHRONICALLY ILL A CO-OPERATIVE TASK

Joseph H Kinnaman, M D , Mincola Discussion Morton L Levin, M D , Albany A COOPERATIVE PROGRAM IN RESTAURANT HYGIENE

Meredith H. Thompson, Dr Eng, Troy (By

invitation)
iscussion Walter D Tiedeman, MCE (By Discussion invitation)

Section on RADIOLOGY

Chairman Raymond W Lewis, M D , New York Vice-Chairman Carlton F Potter, M D , Syracuse Secretary E Forrest Merrill, M D , Rochester

Thursday, May 20-10 00 A.M Hotel Pennsylvania, Salle Moderne

> Round Table Discussion FILM READING SESSION

Interesting proved cases will be presented for discussion Discussion leaders are

Marcy L Sussman, M.D., New York, Chairman

A L Loomis Bell, M D., Brooklyn

Barrey Spillings, M. D., New York

Ramsay Spillman, M.D., New York Harold L. Temple, M.D., New York

Friday, May 21-10 00 A M Hotel Pennsylvania, Penn Top North

OSSEOUS MANIFESTATIONS OF MEDICAL DIS-EASES ROENTGENOGRAPHIC STUDY-ADULTS I. Snapper, M D, New York

- 2 OSSEOUS MANIFESTATIONS OF MEDICAL DIS-EASES ROBENTOEMOGRAPHIC STUDY—CHILDREN Edward B D Neuthauser, M D., Boston Massachusotts (By invitation) Discussion of Papers Henry L. Jaffe M.D., New York
- 3 CARCINOMA OF THE CERVIX UTERI ANALYSIS OF TREATMENT AND RESULTS, 1928-1942 John W Karr, M.D., Rochester Discussion James A. Corceaden, M.D., New York S.R. Snow, Jr. M.D. Rochester

Section on SURGERY

Chairman Secretary Soymour G. Clark, M.D., Brooklyn Dan Mellen, M.D., Rome

Thursday, May 20-10 00 A.M Hotel Pennsylvania Keystone Room

Joint Meeting with the Section on Medicine

Panel Discussion Thyrotoxicosis Its Treatment

Speakers

David P Barr M.D., New York, Moderator Grosvenor W Bissell, M.D., Bullalo Emil Goetsch, M.D., Brocklyn Frank Howard Lahey M.D., Boston Massa chusetts (By invitation) Thomas H. McGavack, M.D. New York William Crawford White, M.D., New York

Friday, May 21—10,00 A.M. Hotel Pennsylvania, Keystone Room

- 1 IMPORTANCE OF NODULAR GOITER IN RELATION TO CANCER OF THE THYROID GLAND John C. McClintock, M.D. J. Albany Discussion William B Parsons, M.D., New York
- 2 SUBGICAL TREATMENT OF INTESTINAL ANOM ALIES IN THE NEWBORN C. Douglas Sawyer, M.D., Brooklyn Discussion Edward J Donovan, M D New York
- SURGICAL TREATMENT OF BILIARY TRACT LE-

Frank Howard Lahey, M.D., Boston, Massa chusetts (By invitation) Discussion Ralph Colp M.D. New York

4 STATATIECTOMES IMPICATIONS AND VALUE
Frederick S. Wetherell M.D., Syracuse
Discussion J William Hinton M.D New
York

Section on UROLOGY

Chairman Francis Patton Twinem M D New York Vice-Chairman

William J Kennedy, M.D., Gloversville Secretary William A Milner M.D. Albany

Friday, May 21—10:00 A.M Hotel Pennsylvania, Conference Room 2

- PATCHOSOMATIC STUDIES OF BLADDER FUNCTION Stewart Wolf, M.D., New York (By invitation)
 G. A. Humphreys, M.D., New York Leonard R. Straub, M.D., New York Herbert S. Ripley, M.D., New York (By invitation)
 - Discussion David H. MacFarland M.D. Utica
- 2 CHAULMOOGRA OIL AND STREPTOMICIN IN THE TREATMENT OF TUBERCULOSIS OF THE URINARY TRACT George R. Slotkin, M.D., Buffalo Discussion John K. Lattimer M.D. New
 - Discussion John K. Lattimer M.D. New York Stanley Wang M.D. New York The Tonus of the Upper Urinary Tract and
- ITS INFLUENCE ON REMAL DYNAMICS AND AB SORPTION Peter A. Narath M.D., Yorktown Heights Discussion J Sydney Ritter M.D. New
- York
 4 Experiences with Retropuble Prostatiotomy

Francis A. Beneventi, M.D., New York Francis Patton Twinem M.D., New York Discussion Roscoe Borst M.D. Utica

Friday, May 21-2 00 P.M Hotel Pennsylvania, Salle Moderne

1 AMATOMIC AND PHYSIOLOGIC ASPECTS OF CAN CRE OF THE PROSTATE

Charles Huggins, M.D., Chicago Illinois (By invitation)

2. Advanced Carcinoma of the Prostate Hor mone Control Therapt as a Preparation for Radical Perintal Prostatectomy

A. Laurence Parlow, M.D., Rochester W W Scott, M.D., Rochester Discussion of Papers Roy B Henline M.D., New York Francis O Harbach M.D., Syracuso

New York Francis O Harbach M D , Syracuso
WHAIS TUNOR DIAGNOSIS AND TREATMENT
(STUDY OF A LARGE SERIES)
Charles T HAZZAZ, M.D , New York

Discussion Meredith Campbell, M.D., New York 3

TUMORS OF THE TESTES Nathan Chandler Foot, M D, New York Discussion Arthur Purdy Stout, MD, New

VISCERAL INVOLVEMENT IN MULTIPLE MYE-TONY Jacob Churg, M D, New York
Alvin J Gordon, M D, New York
Discussion Maurice N Richter, M D, New
York, I Snapper, M D, New York

Thursday, May 20-2 00 P M Hotel Pennsylvania, Parlor 2

1 GIANT FOLLICLE LYMPHADENOPATHY S E Cohen, M D, Elmira
V W Bergstrom, M D, Binghamton
Discussion Joseph C Ehrlich, M D, New
York, William Harris, M D, New York

PREDICTIONS OF ERYTHROBLASTOSIS IN THE Unborn Child by Antenatal Blood Tests A S Wiener, M D, Brooklyn
Discussion Lester J Unger, M D, New York

SURFACE ACTIVE SOLVENTS IN TOPICAL ANTI-BIOTIC THERAPY

Edwin J Grace, M D, Brooklyn Vernon Bryson, Ph D, Cold Spring Harbor (By invitation) Discussion Harold A Abramson, M.D., New York

Section on PEDIATRICS

George R. Murphy, M.D., Elmira Chairman Vice-Chairman

Caldwell, $M\ D$, New York Jerome Glaser, $M\ D$, Rochester George W Secretary

> Thursday, May 20-10 00 A.M Hotel Pennsylvania, Parlor 2

RECENT CONTRIBUTIONS TO THE DIAGNOSIS AND TREATMENT OF PERTUSSIS

William L Bradford, M.D., Rochester Discussion Jerome Kohn, M.D., New York

SURGERY IN CHILDREN
Edward J Donovan, M D, New York
Discussion John Aikman, M D, Rochester,
R Franklin Carter, M D, New York

ORTHOPEDIC MANAGEMENT OF FOOT PROBLEMS in Children Fred L Liebolt, M D, New York Discussion Fred W Bush, M D, Rochester

REPORT OF STUDY OF CHILD HEALTH SERVICES George M Wheatley, M D , New York

Friday, May 21—10 00 A.M Hotel Pennsylvania, Parlor 2

Discussion Paul W Beaven, M D, Rochester

RADIUM THERAPY TO NASOPHARYNX IN ASTH-MATIC CHILDREN Ernest A. Weymuller, M D, New York Discussion Will Cook Spain, M D, New York, George R. Brighton, M.D., New York

CARE OF THE NEWBORN Stewart H. Clifford, M D, Boston, Massachusetts (By invitation)
Discussion William J Orr, M D, Buffalo

COMMON ERRORS IN PEDIATRIC PRACTICE Harry Bakwin, M D, New York Discussion John D Craig, M D, New York

Section on PUBLIC HEALTH, HYGIENE, AND SANITATION

Chairman Secretary

Philip J Rafle, M D, New York F E Coughlin, M D, Troy

Wednesday, May 19-10 00 A.M Hotel Pennsylvania, Manhattan Room West

Symposium

Tuberculosis

Modern Approach to Tuberculosis 1 Herman E Hilleboe, M D, Albany

2 NEW DEVELOPMENTS IN BCG VACCINATION Konrad E Birkhaug, M D, Albany

NEW DEVELOPMENTS IN LABORATORY TECHNICS 3 Bernard Davis, M D, New York (By invi Discussion of Symposium Arthur B Robins, M D, New York

Thursday, May 20-2 00 P M Hotel Pennsylvania, Manhattan Room West

Nonspecific Reactions in Serologic Tests FOR SYPHILIS Victor N Tompkins, M D , Albany Discussion William A Brumfield, Albany

CARING FOR THE CHRONICALLY ILL A Co-OPERATIVE TASK Joseph H. Kinnaman, M D, Mineola

Discussion Morton L Levin, M D, Albany A COOPERATIVE PROGRAM IN RESTAURANT

HYGIENE Meredith H. Thompson, Dr.Eng, Troy (By invitation) Walter D Tiedeman, MCE. (By Discussion invitation)

Section on RADIOLOGY

Raymond W Lewis, M.D., New York an Carlton F Potter, M.D., Syracuse E Forrest Merrill, M.D., Rochester Chairman Vice-Chairman Secretary

> Thursday, May 20—10 00 A.M Hotel Pennsylvania, Salle Moderne

> > Round Table Discussion FILM READING SESSION

Interesting proved cases will be presented for discussion. Discussion leaders are Marcy L Sussman, M D, New York, Chairman

A L Loomis Bell, M D , Brooklyn Ramsay Spillman, M D , New York Harold L Temple, M D , New York

Friday, May 21-10 00 A M Hotel Pennsylvania, Penn Top North

OSSEOUS MANIFESTATIONS OF MEDICAL DIS-EASES ROENTGENOGRAPHIC STUDY-ADULTS I Snapper, M D, New York

TEACHING DAY

Arranged by
The Council Committee on Public Health and Education
of the
Medical Society of the State of New York

O W H MITCHELL M.D, Chairman

Tuesday, May 18, 1948

Hotel Pennsylvania Keystone Room

Charles D Post, M D Syracuse Presiding

Part 1

NUTRITION

Part 3

Panel Discussion

MODERN TRENDS IN MEDICAL CARE

2:00 r M.

Louis H Bauer, M D Hempstead, President, Medical Society of the State of New York, Prending T C Routley, M D., Toronto General Secretary Canadian Medical Association George F Lull, M. D Chicago, Secretary and General Manager American Medical Association

9 30 a.m.

- Some Newer Aspects of Profess Utilization
 David Schwimmet, M.D., New York Associate Visiting Physician, Motropolitan Hospital, Associate in Research, New York
 Medical College Flower and Fifth Avenue
 Hospitals
 Horosas H McGavack M D New York
 Professor of Clinical Medicine, New York
 Medical College, Flower and Fifth Avenue
 Hospitals
- 2 THE INFLUENCE OF DIREARS ON NUTRITIONAL REQUIREMENTS
 HETCHT POllack, M.D., New York Associate Physician and Chief of Metabolic Division,

Mt. Sinal Hospital
John Bookman, M.D. New York, Assistant
Resident for Metabolic Diseases Mt Sinai
Hospital

Part 2

REHABILITATION AND PHYSICAL MEDICINE

DYNAMIC THERAPEUTICS IN CHEOMIC DIS-EASE WITH A CLIMICAL DEMONSTRATION HOWST A Rusk, M.D., New York Professor of Rohabilitation and Physical Medicine New York University College of Medicine Associate Editor New York Times

Each lecture will be approximately thirty minutes followed by general discussion

These lectures are presented by the Medical Society of the State of New York with the cooperation of the New York State Department of Health.

Part 4

ROUND TABLE CONFERENCE ON MEDICAL CARE INSURANCE IN NEW YORK STATE A. H. Aaron M D., Buffalo Chairman, Subcommittee on Medical Expenso Insurance of the Council Committee on Economics Prending

Benefits Offered by Voluntary Nonphofit Medical Carb Insurance Plans in New York State

Carlton E. Wertz, M.D., Buffalo Prosident Western Now York Plan Inc

2 ADVANTAGES OF A SERVICE CONTRACT FOR LOW INCOME SUBSCRIBERS Milton J. Goodfriend, M.D., New York, Board of Directors United Medical Service

3 PROGRESS REPORT ON VOLUNTARY NONFROFIT MEDICAL CARD INSURANCE PLANS IN NEW YORK STATE

George P Farrell, New York, Director Bu reau of Medical Care Insurance Medical Society of the State of New York

HOME TOWN MEDICAL CARE OF VETERANS UNDER VETERANS MEDICAL SERVICE PLAN INC. Herbert H. Bauckus, M.D. Buffalo Presi

dent, Veterans Medical Service Plan of New York Inc.

QUESTION PERIOD

SCIENTIFIC EXHIBITS

Hotel Pennsylvania, New York, May 17 to 21, 1948

J G Fred Hiss, M D, Chairman, Syracuse and Theo J Curpher, M D, Hempstead

GRAND BALLROOM

RADIOACTIVE ISOTOPES IN BIOLOGY AND MEDICINE

Edith H Quimby, Sc.D
Charlotte Schmidt, B A.
College of Physicians and Surgeons, Columbia
University, New York

A number of charts presenting such topics as nature and production of radioactive isotopes, measurement of isotope quantity and radiation dosage, safety precautions in using isotopes, making of radioautographs, tracer and therapeutic uses of various isotopes

NUTRITIONAL ASPECTS OF CONVALESCENCE

Herbert Pollack, M.D John Bookman, M D Mt Sinai Hospital New York

A series of charts and tables analyzing the nutritional requirements of normal and convalescent people. The standard therapeutic diets are illustrated and their nutritional value calculated. Protocols on actual patients will be demonstrated, illustrating the importance of revising current therapeutic diets.

BALCONY OF GRAND BALLROOM

OMMITTEE FOR THE IMPROVEMENT OF CHILD HEALTH

American Academy of Pediatrics

Charts show the preliminary findings of the twoyear, nation-wide study of Child Health Services and the implementation program of the Committee for the Improvement of Child Health—the amount of child care by hospitals, community health agencies, and physicians, distribution of these services, variations between states, and comparisons between the services for children provided by general practitioners and pediatricians—The extent of the general practitioners' and pediatricians' hospital training in pediatrics is given special emphasis

Charts based on visits and questionnaires to medical schools, with particular reference to pediatric education, include comparisons in budgets and variations in use of pediatric teaching hours. Diagram shows the implementation program of the Academy's Committee for the Improvement of Child Health at the national level and its integra-

tion with state programs

CHILDREN AND THEIR OCULAR SYMPTOMS

Commission for the Blind New York State Department of Social Welfare

Posters and kodachromes illustrate congenital cataracts, the effect of certain conditions such as measles, strabismus, and interstitial keratitis, and the relationship of systemic diseases to the eyes

Coccidioidomycosis in Veterans of World War Π

H E Bass, M D
Alexander Schomer, M D
Rudolph Berke, M D

New York Regional Office, Veterans Administration, Thoracic Unit New York

Maps and charts showing a series of cases with pulmonary lesions of coccidioidomycosis. The disease was contracted while stationed in the endemic area during World War II. The residual lesions include pulmonary infiltrates of various types, cavities, pleural effusion, and the disseminated or granuloma form. Cases showing pulmonary lesions which have persisted for several years and which have a close resemblance to tuberculosis. Several cases were initially mistaken for tuberculosis after return to civilian life in New York City. A history of residence in the endemic area in former army personnel with pulmonary infiltrations is of aid in the diagnosis of coccidioidomycosis.

A Program in Physical Medicine

William Benham Snow, M D Columbia-Presbyterian Medical Center New York

A fixed exhibit illustrating the educational program in physical medicine, for undergraduate and postgraduate, technician and physician, the organization for coverage of detail in physical medicine in the general and special hospitals at the Medical Center, the methods of treatment used in care supplementing the usual medical and surgical care of the patients, and the indications and opportunities for research in the field

CLINICAL COURSE OF GLAUCOMA

Adolph Posner, M D Abraham Schlossman, M.D New York

Tables and graphs illustrating the clinical fea-

tures of primary glaucoma based on an analysis of 373 cases from private practice. Case histories of several patients who have been observed for many years will show, by means of tension curves and field charts, the evolution of the disease

AMPRETAMINE SULFATE THERAPY OF ACUTE BARBI TURATE POISONING

> A. W Freireich, M.D. J. W Landsberg, M.D. Meadowbrook Hospital Hempstead

Charts showing results in 60 cases of acute barbiturate poisoning Demonstrations of rapid method for testing for barbiturates in urine, barbiturates extracted from urine, and gastric contents of pationta

NUTRITIONAL DISORDERS IN INFANTS

J. H. Lapin, M.D. C. T. Fried, M.D. W. W. Weissberg, M.D. Bronx Hospital New York

Twelve cases of pylorospasm are presented in which cessation of symptoms followed the substitution of nutramigen for milk formulas. A possible explanation is offered, nutramigen eliminates the milk allergy factors and exerts a buffering action on the stomach acids. Twelve cases of treated allergo colitis are presented with a differential diagnosis and a description of the distinctive sigmoidoscopic picture

STUDIES WITH STEAM-GENERATED AEROSOLS

Samuel J Prigal, M.D. New York Medical College, Flower and Fifth Avenue Hospitals New York

Part I describes the apparatus a combined steam-generator and aerosoliser which is capable of producing aerosols of a variety of solutions such as aminophyllin, ammonium chloride, epinephrin benadryl, penicillin streptomycin, and sulfonamides. In addition, several methods of confining and con serving the acrosol by means of a tent, breathing box, and a closed chamber, are described

Part 2 records blood levels of penicillin and strep-

tomycin obtained by inhalation of aerosols.

Part 3 is the clinical evaluation of the use of aminophyllin aerosol in the treatment of asthma and in the treatment of infections in the respiratory tract, using penicillin in aerosol form. The protract, using penicillin in aerosol form. The pro-phylactic application of penicillin aerosol in respir atory diseases is emphasized

OUR HEARING MECHANISM

Victor L. Browd, M.D. Polyclinic Hospital New York

A method of presenting the anatomy and physiology of the auditory apparatus to graduate students and practitioners of modicine, educators, technicians, and others interested in the problems of the hard of hearing. Its purpose is to stress the contribution of each of the component parts of the hearing machine to hearing aculty, thus establishing a guide to the location nature, and treatment of the lesions commonly found in the hard of hearing. STUDIES ON ANTI ULCER FACTORS ORAL THERAPY OF CHRONIC PEPTIC ULCER

> Robert Clinton Page, M D R. R. Heffner, M.D Z. T Bercovitz, M.D H. K. Russell, M.D. C. C. Fuller, M.D.
> J. A. Marks, M.D.
> New York Post-Graduate Hospital New York

Use of an anti-ulcer substance extracted from the urine of pregnant marcs for the treatment of chronic duodenal ulcers illustrated Roentgenographic evi dence of its effect on ulcor healing compared with a suitable control group

VASCULAR DAMAGE IN DIABETES MELLITUS

Henry Dolger, M.D. Mount Sinai Hospital New York

Accelerated arteriosclerosis is characteristic of diabetes mellitus. Generalised degenerative changes affect the capillaries, particularly the vessels of the retina, kidney, and vasa vasorum. This damage can be found in varying degrees of severity in every instance of diabetes mellitus of some duration. All diabetic patients should be examined regularly for early evidences of vascular damage as manifested by retinal hemorrhage, albuminum, or hypertension Within twenty five years of onset of diabetes, 200 patients reveal retinopathy in 100 per cent, hyper tension and albuminuria in 50 per cent Neither the age of onset, nor the severity of diabetes, nor the control of glycosuria prevent the premature development of vascular degeneration.

SEVENTY FIVE YEARS OF PUBLIC HEALTH IN NEW YORK STATE

> Thomas C. Stowell, M.D. Drymon of Public Health Education New York State Department of Health Albany

Pictures and animated graphs show the striking story of public health in New York State during the past seventy five years as reflected in lowered mor tality rate and rising life expectancy Details of im provements as well as the challenge for the coming vears.

VACCINATION AGAINST TUBERCULOSIS WITH BCG VACCINE

> Gilbert Dalldorf, M D Division of Laboratories and Research New York State Department of Health Albany

An historic and scientific review of BCG vaccina tion from the first work of Calmette and Guerin at the Pasteur Institute of Lille France in 1906 to its preparation and distribution in New York by the State Department of Health with the advice of the Medical Society of the State of New York. Mothods for the preparation of the vaccine at the Division of Laboratories and Research are shown, together with control tests for its purity and attenu ated virulence when injected subcutaneously, intra cutaneously, and transcutaneously in normal guinea The multiple puncture vaccination method in man is demonstrated also

PUBLIC HEALTH AS A CAREER

Granville W Larimore, M D Office of Public Health Education New York State Department of Health Albany

This exhibit aims at portraying for the physician the splendid opportunities now offered by a career in public health. It shows pictorially typical examples of the activities of public health physicians and presents graphically the advantages of public health as a specialty together with information on positions now available in New York State

Complications of Diabetes Mellitus

Williams S Collens, M D J D Zilinsky, M.D
L C Boas, M D
N D Wilensky, M.D
J Greenwald, M D
Maimonides Hospital (Israel Zion Division)
Brooklyn

Color prints illustrating the following complicalipoatrophy, lipohypertrophy, tions in diabetes insulin sensitivity, insulin edema, arteriosclerotic degeneration, acute arternal occlusion, types of gangrene, neuropathies showing cases with muscle atrophy, Kimmelstiel-Wilson syndrome showing anasarca, retinopathy, and photomicrographs of kidneys, rare types of kanthomas such as kanthoma of cornea, necrobiosis lipoidica diabeticorum, angular stomatitis, and cheilosis

LIFE SITUATIONS, EMOTIONS, AND GASTRIC FUNC-

Stewart Wolf, M D Harold G Wolff, M D New York Hospital New York

Historic data and pictures of Beaumont, Pavlov, and Cannon with a brief account of their contributions

2 Data on "Tom," our subject with a gastric fistula, describing the method of study and the circumstances under which gastric hypofunction on the one hand and hyperfunction on the other

3 Findings in patients with symptoms of gastric hypofunction, i.e., feelings of nausea and vomiting, and hyperfunction, 1 e, gastritis and peptic ulcer

QUANTITATIVE MICRO METHODS IN CLINICAL MEDICINE

> Albert E Sobel, Ph.D Albert Hanok, BS Samuel Natelson, Ph D Jewish Hospital of Brooklyn Brooklyn

Demonstrating the use of (1) microburets, capillary burets, and fine pipets which permit sampling of and titration with small volumes of liquid with a precision of 0 0001 to 0 00001 ml, (2) more sensitive indicators for determining the end point which allow titration with more dilute standard solutions, (3) dyes for titration, like dichlorophenol, indophenol, and dithizone, whose color changes at the equivalence point are perceptible at dilutions as low as 0 00005 normal, (4) the spectrophotometer and the photoelectric colorimeter (using an almost menochromatic light) which permit more sensitive measurement of colors at the wavelength of maximum light absorption, (5) horazontal cuvette in which a longer light absorption path is possible for a small volume of colored soli (6) colorimetric reactions of higher colo intensity

These principles will be illustrated by a numb of typical methods requiring from 002 to 01 m of blood serum for the following determination urea, calcium, total base, sugar, inorganic phosphat sulfa drugs, vitamin A.

PLASTIC AND RECONSTRUCTIVE SURGERY

Herbert Conway, M D Clarence R. Straatsma, M D
Cornelius J Kraissi, M D
Robert H Clifford, M.D
Jerome Gelb, M D Leo L Leveridge, M.D. Julius M Joseph, M D Samuel Climo, M D Richard B Stark, M D Veterans Administration Hospital Вголх

Moulages demonstrating the phases of recor struction of congenital, traumatic, and postopera tive defects of the external ear

Photographs and moulages demonstrating the use of abdominal flaps, skin lined, to cover defect of the face, upper and lower extremities

Photographs and drawings demonstrating th use of pedicle flaps consisting of full thickness of ski and subcutaneous tissue from one leg to cover de fects of the opposite extremity

TREATMENT OF LEG ULCERS BY DAXALON PAST AND DOME BOOT

> William M Cooper, M D Polychme Höspital New York

Illustrated placards and actual photographs cases of leg ulcers successfully treated with daxalo paste and dome boot Exhibit attempts to illus trate importance of consideration of fundaments etiology and pathology of leg ulcers

VALUE OF CAVERNOSTOMY IN THE TREATMENT O PULMONARY TUBERCULOSIS

> S A. Thompson, M D I Shiner, M D E E Rockey, M D New York Medical College Metropolitan Hospital New York

Photographs, x-ray films, drawings, charts, and data illustrating the problems of surgical technic Five-year follow-up of 22 cases

Advantages of Internal Fixation in Fracture

Leo Faske, M D Alfred L Shapiro, M D Cumberland Hospital Brooklyn

Radiographs, charts, and models of clinical experiences with 200 cases of major fractures in civil ians treated by open reduction and internal skeleta fixation during a five-year period Advantages and relative safety in the operative treatment of fractures with adjuvant sulfonamide and penicilin therapy are detailed Methods of fixation found mos satisfactory from the viewpoint of functional resul and decreased morbidity illustrated

INTERVERTEBRAL FORAMEN STUDIES

Lee A. Hadley, M.D. Syracuse

Anatomic specimens with corresponding radiographs and biopsy sections, some of them embedded in plastic. Normal and abnormal intervertebral foramens are illustrated

CHEST AND SHOULDER PAIN
TREATMENT BY BLOCK OF SOMATIC TRIGGER AREAS

Janet Travell, M.D
Seymour H. Rinder, M.D
Audrie L. Bobb, M.D
Lawrence V Hanlon M.D
Cornell University Medical College
Beth Israel Hospital
New York

About 400 patients with chest and/or shoulder and arm pain, who had trigger areas in the muscle of the shoulder gurdle, were studied Etiologic factors, including viscorosomatic reflexes, are indicated Usually, pain was amenable to local block of trigger areas, i.e., infiltration of affected muscles with procaine bydrochloride or spraying the over lying skin with ethyl chloride Details of technics are shown. Success with these methods depends on finding trigger areas which are sources of pain. This requires knowledge of specific patterns or referred pain for voluntary muscles. Several patterns are portrayed which appeared frequently in these somatic pain syndromes.

SURFACE ACTIVE SOLVENTS IN TOPICAL ANTIBIOTIC
THURAPY

Edwin J Garce, M.D Grace Clinic Brooklyn Vernon Bryson, Ph.D Long Island Biological Association Cold Spring Harbor

Methods and chinical results of topical administration of penicillin and streptomycin in solutions of reduced surface tension with enhanced penetrative and detergent capacity Experimental evidence is presented to show that in combination with selected surface active chemicals, the activity of penicillin is synergistically enhanced when tested against both normal and penicillin-resistant bacteris is strains.

Clinical significance of multiple chemotherapy is considered in relation to origin of bacterial resistance to pencilin and streptomycin. Advantages of topical application and increased penetrative capacity are exhibited as of fundamental importance in treatment of areas of isolated infection

Clinical experience in aerosol therapy and other forms of topical administration reviewed in cases of respiratory disease including tuberculosis and, in general, pyogenic infections of soft tissue and bone

THE NUTRITIONAL BASIS OF CERTAIN ENDOGRINE DISORDERS

Morton S. Biskind, M.D Beth Israel Hospital New York

Evidence is presented that impairment of hepatic function on a nutritional basis is ethologically related to endocrine disturbances in which the estrogen-androgen equilibrium is altered (in the female menometrorrhagia, cystic mastitis, premenstrual tension neoplasms of breast and uterus certain

types of dynmenorrhea postpartum subinvolution of the uterus, in the male diminished libido and potency, testicular atrophy, infertility gynecomastia, and certain types of endocrine obesity) and in diabetes Lesions of avitamnoes which occur in these conditions (and, in the case of menometror rhagis, the associated estrogenic endometriums) and healing of the avitaminotic lesions under nutritional therapy in association with subsidence of the endocrine disorders, are illustrated in kodachrome

TREATMENT OF CHRONIC SALPINGITIS WITH BENEYL CINNAMATE ESTER (JACOBSON'S SOLUTION)

> Morris I. Elsenstein, M.D Harlem Hospital New York

A female pelvic anatomic chart as well as one showing result of therapy

American Association for the Study of Goiter Committee on Thyrod Cancer

> Allen Graham, M.D Eastchester John C. McClintock, M.D Albany Gustavus H. Klinck, Jr., M.D Troy

Colored photomicrographs illustrating enteria for diagnosis of malignant disease of the thyroid gland and typical examples of various types of neoplasms of this organ. Age and sex incidence shown by charts and posters

THE GASTROESOPHAGEAL CIRCULATION AND IN NERVATION

Gregory L Robillard, M.D Alfred L. Shapiro M.D Brooklyn Cancer Institute Brooklyn

The surgical and variational anatomy of the artorial and venous circulation and vagal and sympathetic nerve supply primarily of the thoracic copingus and upper atomach, presented in a sories of mounted dissections transparent specimens diagrams, and charts Clinical significance of these structures, with particular reference to the operative procedures of esophagectomy vagotomy and gastrectomy illustrated.

Midplane Angle Pelvinerry Gemma Barzilai, M.D New York

Charts illustrating a new system of pelvimetry give evidence of the relationship between the morphologic characters of the obstetric pelvis and the mechanism of labor

OSSEOUS TUMORS IN CHILDHOOD

Harold W Dargeon, M.D Bradley L. Coley M.D Norman L. Higginbotham, M.D Memorial Hospital New York

Tumors of the bones in childhood may clinically simulate a variety of diseases. Trauma, acute and chronic infections rheumatic fever, orthopedic defects, vitamin deficiencies, and endocrine disorders may produce symptoms which resemble bone tumors. Examples of esseous tumors and diseases of bone from which they must be differentiated are shown sented

POLYPS OF THE COLON AND RECTUM

George E Binkley, M D Michael R. Deddish, M D Douglas Sunderland, M D Memorial Hospital New York

Transparencies illustrating diagnosis, treatment, and histologic appearance of miscellaneous polyps of the colon and rectum

WILMS' TUMORS IN CHILDREN

Charles Hazzard, M D
Meyer Melicow, M D
Reginald Seidel, M D
Columbia-Presbyterian Medical Center
New York

Tables and charts illustrating clinical facts, therapy, and pathology relating to 23 cases of Wilms' tumors in children admitted to the Pediatric Department and Squier Urological Clinic of the Columbia-Presbyterian Medical Center from 1931 to 1947, inclusive

Clinical photographs and photographs of gross

Clinical photographs and photographs of gross and microscopic pathology material Photographs of radiographs to include pyelograms and metastatic lesions and kodachromes relating to the cases pre-

ASPIRATION OF BONE MARROW FROM THE ILIAC CREST TECHNICAL AND DIAGNOSTIC ADVANTAGES

Michael A. Rubinstein, M.D Montefiore Hospital New York

Bone marrow can be obtained easily, safely, and repeatedly from the iliac crest. It may at times provide information not obtainable from the sternal aspiration.

Studies of bone marrow were performed simultaneously in sternal and iliac aspirations in nearly

300 different cases The diagnostic advantages of iliac versus sternal bone marrow studies were seen in some cases of infiltrative diseases of the bone marrow, such as metastatic lesions of various neoplastic diseases, multiple myeloma, and some early phases of leukemia

Examples are abstracted where the diagnosis was arrived at on the basis of iliac bone marrow studies

Management of Erythroblastosis Fetalis

Harry Wallerstein, M D
Alfred Schwarz, M D
Jewish Memorial Hospital
Morrisania City Hospital
Queens General Hospital
New York

Kodachromes depict basic pathology believed responsible for failure of former methods of therapy Former routines and resultant mortality rates compared with present series. Criteria for diagnosis and indications for blood substitution and other forms of treatment are given with significant case histories. Methods of blood substitution (including sagittal sinus, radial artery, and umblical vein technics) illustrated by kodachromes and manikin

Isoimmunization with the A and B Factors and Its Relation to Hemolytic Disease of the Newborn

Sılik H Polayes, M D Cumberland Hospital Prospect Heights Hospital Brooklyn

Charts, figures, and photographs of gross and microscopic specimens showing that the high titer anti-A and anti-B agglutinins in mothers of heterospecific pregnancy may be pathogenetically related to the hemolytic disease which occurs in certain newborns whose mothers are Rh positive

EXHIBIT AREA PARLOR A PARLOR B

EFFECT OF VARIOUS ESTROGENS ON THE VAGINAL MUCOSA

Mildred Vogel, Sc D
Thomas H McGavack, M.D
Joseph Mellow, M.D
Metropolitan Hospital Research Unit
New York

Single injections of estrogenic preparation were administered to postmenopausal, menopausal, and castrated women. The estrogens included estradiol, estradiol benzoate, estradiol dipropionate, and estrone. Prior to and for several days after each injection, vaginal smears were studied. One hundred and sixty test cases have been observed. Changes in the smears were recorded so that the data shows for each estrogenic preparation used. (a) lag-time, i.e., the time necessary to observe any effect, (b) the duration of action of the hormone, and (c) the degree of estrogenic response obtained.

Water color plates, charts, and graphs summarize the data and illustrate the types of vaginal smears

observed

BASAL CELL EPITHELIOMA

Anthony C Cipollaro, M D
Wilbert Sachs, M.D
Adrian Brodey, M D
New York Medical College
Flower and Fifth Avenue Hospitals
New York

Clinical photographs, photomicrographs, and charts, illustrating the essential features of basal cell epitheliomas with emphasis on the pigmented type

THE DIAGNOSIS, LIFE HISTORY, AND RADIATION THERAPY OF PITUITARY TUMORS A CLINICAL STUDY OF 25 CASES, 1937 TO 1947

Bernard Roswit, M D
Archie Sheinmel, M.D
Gustave Kaplan, M.D
U S Veterans Administration Hospital
Bronx

The tumors of the pituitary gland are of special interest because of their profound endocrine dis-

turbances the threat to vision and striking response to miliation therapy. Our ten-year experience with 25 cases of pituitary adenomas, ecsinophile, basephile, and chromophobe types presented. Graphic description of the clinical and reentgen disgnosis, the dynamic life history of the disease and the results of radiation therapy. The diagnosis and treatment of these interesting tumors are best accomplished by team work on the part of the general modical practitioner ophthalmologist, neurologist, and radiologist.

SARCOMAS INDUCED IN RATE BY IMPLANTING CELLO-

B S. Oppenheimer, M.D A. P Stout, M.D E. T Oppenheimer, Ph.D Department of Cancer Research Columbia University New York

Method of production of tumors in rats Frequency nature, and transplantability Gross specimens and microphotographs Experimental results should be taken into consideration in the matter of surgical implantation of cellophane in man

OSTEOPATHES ENCOUNTERED IN THE ENDOCRINE CLINIC

Rita S Finkler, M.D George M Cohn, M.D N James Furst M D Newark Both Israel Hospital Newark, New Jersey

The group consists of thyropituitary dysfunction Turnor's syndrome, Lorain Levi dwarfism hypogenitalism with fibrous dysplasm of bone pseudo-froehlich's syndrome with actoogenesis imperfects, pituitary adenome with acromegalic manifestations macrosomia genitalis with accelerated bony maturation, and a differential diagnosis of octoopathies. These patients have been referred by various sources and have demonstrated a common denominator of occous pathologic change. In some instances, the etiology could be definitely assumed to be endocrine dysfunction, in others, no definite one obscure disconnection of the examination of the cases were referred under the assumption that some obscure endocrinopathy was present Clinical photographs, x ray prints, laboratory data

CRITERIA FOR EFFECTIVE VARICOSE VEIN THERAPT

I. A. Brunstein, M.D. Stuyvesant Polyclinic New York

Interpretation of the Trendelenburg test in relation to the anatomic distribution of varices veins in the lower extremities is evaluated. Criteria for the selection of the proper method of treatment of individual cases of varicesities are presented. An appliance with which to execute the Trendelenburg test in cases with wide distribution is shown

STERILITY ITS CAUSES, INVESTIGATION AND TREATMENT

Samuel L. Siegier, M.D Unity Hospital Brooklyn Women s Hospital Brooklyn

Causes of sterility, methods of investigation, and results in a series of 1 500 infertility cases. The ex

hibit is in the form of a book so that one can peruse it in series Each page contains a different factor showing the probable cause of the infertility Photographs (colored and black and white) and/or lined drawings. The final page shows the results in the treatment of these infertility cases both in legend and pic chart demonstration.

HISTAMINE ANTAGONISTS IN ALLERGY

Emanuel Schwartz, M.D
L. Levin M.D
H Leibowitz, M.D
I. M Kurtz, M.D
J Reicher, M.D
J F Kelly, M.D
J Wolf, M.D
Long Island College of Medicine
Long Island College Hospital
Brooklyn

A comparative experimental and clinical study of pyribenzamine, benadryl, antistine, neobetra mine theophorin (Nu 1504) histadyl (01018), and neo-antergan Transparancies illustrate the effects of the antihistaminic drugs on histamine and aller gae skin wheals and cumulative data relating to their clinical value and limitations

CARDIOVASCULAR ALLERGY

Joseph Harkavy M.D Mount Sinai Hospital New York

Part 1 deals with clinical syndromes in the peripheral vessels and heart resulting from hyper sensitiveness to tobacco foods, drugs, serums, and idhalants (a) thrombo-angilitis obliterans, migrating phlebitis intermittent claudication (b) cardiac arrhythmias, i.e. premature contraction paroxys mal tachycardia, and auricular fibrillation angina pectoris and coronary artery discoss.

Part 2 deals with hyperergic vascular discase.

Part 2 deals with hyperergic vascular disease associated with bacterial allergy, acute arteritis, neorotising arteritis, endarteritis obliterans and perparteritis nodesa which give rise to bronchial astima, migrating pulmonary infiltrations with cosmophilia, cardiac and renal involvement, polysoroeitis, otc.

MANAGEMENT OF ARTERIAL EMERGENCIES

Jere W Lord, Jr. M.D Lester Breidenbach, M.D Frederic W Bancroft, M.D Thomas J O'Kane, M.D S. Potter Bartley M.D

New York and Brooklyn Regional Committee on Fractures and Trauma of American College of Surgeons

The management of injuries to a major artery resulting from an accident outside the hospital or an injury during the course of an operation is presented. Vascular equipment, first aid and emergency hospital treatment, definitive surgical precedure and postoperative care are outlined and illustrated. The surgical management of arterial embolis discussed. Organization of vascular teams within each hospital is suggested to carry out these procedures. Photographs illustrating technics of arterial anastomosis and vascular equipment. Placards describing details of pre- and postoperative management. Brechures.

BREAST ENDOCRINE DISTURBANCES OF THE CHRONIC CYSTIC MASTITIS

J H Morton, M D
T H McGavack, M D
New York Medical College, Flower and Fifth
Avenue Hospitals New York

The normal endocrine physiology of the female is depicted from infancy through the menopause A graphic description of the findings in the child-bearing period, illustrated by breast and endometrial biopsies, hormonal assays, vaginal smears, basal temperature charts, and soft tissue x-rays of the breast, is given in detail

The abnormal changes in chronic cystic mastitis are reviewed The estrogen-progesterone imbalance is demonstrated by graphic descriptions and models

Treatment is illustrated by a typical case report. The part played by the hormonal imbalance in this and other clinical entities is shown

ARTERIAL DISEASE IN THE AGED

Benjamin Jablons, M D
R. Donald Beck, M D
Victor A Fink, M D
A H Wolfson, B S
Goldwater Memorial Hospital New York

Study of asymptomatic and symptomatic peripheral vascular disease in aged subjects in relation to changes in other vascular areas, i.e., cerebral, cardiac, renal, etc., and to metabolic disturbances associated with diabetes mellitus, myxedema, nephritis, etc Determination of compensatory vascular adjustments present in asymptomatic arteriosclerosis obliterans arteriography, oscillo-metric surface, and deep temperature determina-Investigation of extent of reflex proximal and distal vasospasm and the effect of various therapeutic measures, 1 e, indirect heat, hypertonic saline, priscol, tubulin Effect on vasospasm and saline, priscol, tubulin vasomotor tone determined by above procedures

Intravenous Procaine

as well as by tissue and capillary pulse studies

David J Graubard, M D. Multon H Waldman, M.D Raphael W Robertazzo, M D Reconstruction Hospital, Post-Graduate Medical School and Hospital

New York Translucid diagrams and pictures showing the normal topography of the capillary unit (after Zweifach), the origin of the stimulus in the unit, early stages of inflammation, and restoration of normal function following intravenous procaine, (2) colored transparencies of sympathetic reflex dystrophy (causalgia) of hands before, during, and after procaine infusions with radiographic pictures, (3) statistical analysis of the types of cases, number of infusions given in each category, the average number of infusions required, and results following use of intravenous procaine, (4) an instrument for regulating the flow of parenteral fluids (intravenous procaine in saline, 5 per cent dextrose in distilled

water, plasma, whole blood, amino acids) TREATMENT OF UPPER RESPIRATORY INFECTIONS WITH BALANCED SUCTION AND PRESSURE

Gervais W McAuliffe, M D George C Mueller, M D

New York Hospital New York

Demonstration of several instruments used in the treatment of infections of the tonsils and the paranasal sinuses using the principle of balanced suction and pressure The development of these instruments over a period of years will be traced by an exhibit of some of the early original instruments

SURGICAL TREATMENT OF RECURRENT ACUTE PANCREATITIS

Henry Doubilet, M D New York University, College of Medicine New York

Diagrams describe the various hormones formed in the intestinal tract and the modes of their separa-tion and purification Various types of secretin are shown and the results obtained by the secretin test described The methods employed for demonstrating the common passageway between the bile and pancreatic ducts are shown by secretin and cholangiographic studies The relation of this condition to recurrent acute pancreatitis is demonstrated and the means of preventing reflux of bile into the pancreatic duct by sectioning the sphincter of Oddi with a special instrument. The results of this operation are demonstrated by cholangiographic and kymographic studies A model of the anatomy of this region is shown

DIAGNOSIS AND MANAGEMENT OF THE POSTCHO-LECYSTECTOMY SYNDROME

> R. Franklin Carter, M D J Russell Twiss, M D New York Post-Graduate Hospital New York

Review of a series of patients having symptoms following operations on the biliary tract, giving procedures employed to determine the cause of the symptoms, the diagnoses of the conditions considered responsible, the medical and surgical procedures utilized in treatment, and the followup re-

EARLY DIAGNOSIS OF CANCER CANCER TEACHING Models

> Leonard B Goldman, M D
> Abram Belskie, F N S S New York Medical College New York

Life-size, full colored, latex models permitting palpation of precancerous lesions and early cancers of various organs and parts of the body models include a head with interchangeable tongues, a female bust demonstrating the radical mastectomy procedure, breasts (cancer, fibroadenoma, cyst, cystic mastitis), gynecologic model with interchangeable cervices, male in knee-chest position for prostatic palpation, and stomach

SHOULDER-HAND SYNDROME IN REFLEX DYSTROPHY DIAGNOSIS AND TREATMENT

> Otto Steinbrocker, M D Richard Marton, M D Bellevue Hospital New York

A pictorial review of this syndrome in its various stages, supplemented by outlines of diagnostic features and etiology A brief summary and an illustration of the postulated underlying mechanism Outline of therapeutic methods with drawings and illustrations of the treatment of choice stellate ganglion block, together with an analysis of immediate results and follow up

DIARRHEAL DISEASES DIAGNOSIS AND TREATMENT
William Z Fredkin M.D
Jowish Hospital of Brooklyn
Brooklyn

Charts, models, specimens, and instruments il lustrating the diagnosis and treatment of diarrheal diseases ELECTROENGEPHALOGRAPHIC STUDIES IN ENCEPHALITIS

> Burton M. Shinners, M.D. Betsey Rochester, M.D. Children & Hoepital of Buffalo Buffalo

Brain-wave studies in the encephalitis pollomyelitis measles mumps chickenpox, and nonspecific encephalitis. In these children we have follow-up records as well as clinical studies in a total group

MEZZANINE

CRUTCHES IN AMERICAN HISTORY Sigmund Epstein, M D New York

Photographs and color prints

CAUSES OF BLINDNESS

Franklin M Foote M.D
National Society for the Prevention of Blindness
Inc.

New York

Presenting graphically and through a series of paintings the leading causes of bindness and indicating the problems in research and education which are of most importance in prevention of blindness programs.

A FIVE-POINT MEDICAL PROGRAM FOR A SMALL INDUSTRIAL PLANT

J M Krich, M.D In Cooperation with Visiting Nurse Service of New York

How a medical program can be instituted in a small industrial plant. Shows the pre-employment examination, safety program treatment of the in dustrial worker the time motion study and other engineering phases and how absenteesim can be reduced. These five points will demonstrate how the medical department functions, what it can accomplish, and the advantages that both labor and management derive

MEDICAL PROCEDURE IN WORKMEN'S COMPENSA-TION

Willis M. Weeden, M.D New York State Workman's Compensation Board New York

Decuments used in preparing a case in compensation, the relationship of the physician to the case the various steps followed illustrating the importance and urgency of the medical reports, the interchationship between (1) the attending physician (2) the carrier's physician (3) the State examiner and (4) possible computants

and (4) possible consultants
Wall charts, examples of forms, and pertinent
points of the law

I THE OF CLIC PART

COUNCIL COMMITTEE ON PUBLIC HEALTH AND EDUCATION

O W H. Mitchell, M.D., Chairman Medical Society of the State of New York Charts show activities of this Committee, emphasizing help given to county medical societies in arranging programs

How the Society Serves the Physician Medical Society of the State of New York

How the Society serves the physician is important to every member This exhibit presents graphically the services of the various departments.

THE DIRECTORY

Medical Society of the State of New York

Here is an opportunity for you to see just exactly what the Directory "Blue Book" contains. The new edition is the largest and best indexed Directory the Society has ever published

Changes in biographic data for the 1949 edition may be left at this exhibit

VOLUNTARY PREPATMENT MEDICAL CARE PLANS

George P Farrell
Bureau of Medical Care Insurance
Medical Society of the State of New York
New York

Colored map of New York State indicating areas served by each of the six voluntary plans, graphs illustrating growth in enrollment and benefits to members.

IBON MEN OF MEDICING

Medical Society of the State of New York

This special exhibit is designed by the Society to give every physician attending the convention an opportunity to view the material included in the special Commemorative Brochure entitled "20 000 Years of Service The brochure is a limited edition, and individual copies will not be available

SERVING THOSE WHO SERVE THE JOURNAL

Medical Society of the State of New York

The New York STATE JOURNAL OF MEDICINE exhibit this year is designed to show that the Journal and the practicing physician are "partners in service.

As an indication of the Journal's editorial focus on the individual physician you are invited to stop and have a free souvenir photograph taken of your self

The Editorial Staff invites your contributions of news items and scientific articles.

ANNUAL REPORTS

MEDICAL SOCIETY OF THE STATE OF NEW YORK

1947-1948

Report of the President

To the House of Delegates, Gentlemen

The past year has been a busy one for the State Society, and it has had many problems to face

One of the first problems was malpractice defense At the 1947 meeting of the House, a and insurance lengthy report was made covering the matter for the past eleven years. New rates were agreed upon It was with a considerable shock, therefore, that the Council learned in September that the Yorkshire Indemnity Company refused to continue carrying our insurance After conferences between the insurance company and the Malpractice Board, the company agreed to continue carrying the insurance at greatly increased rates for downstate New York and at the same rates for upstate The Council was forced to accept these rates in order to protect our members There was no time to make other arrangements. Regardless of whether or not the increased rates are justified, the peremptory action of the insurance company caused considerable re-sentment among the Officers and Council The Malpractice Board is working hard on the subject, and it is hoped that a more satisfactory solution than exists at present can be found. The matter than exists at present can be found. of carrying our own insurance is being carefully studied. A more detailed report will be found in the Report of the Malpractice Defense and Insurance Board. The Board deserves the confidence of the Society as it is in no way responsible for the present situation.

The JOURNAL continues to grow in circulation and editorial standards Dr Kosmak is deserving of in editorial standards the gratitude of the Society for the able manner in which he has managed the JOURNAL. I am considerably concerned, however, about the advertising content of the JOURNAL. Our JOURNAL is one of four state journals that does not adhere to the standards of the American Medical Association, Council on Pharmacy and Chemistry This Council was organized in 1905 to establish a series of principles that would aid in differentiating between useful and useless drugs, between those sold with honest and dishonest claims, between those based on scientific evidence and those sold without such evidence. It has served notably for the advancement of medical science. The Council and scientific medicine deserve the earnest support of our members and of our

Society The editorial standard of our JOURNAL is high and constantly increasing. The advertising stand-ard, although somewhat better than a year ago, is not on the same plane. I feel that it is most unfortunate that we cannot look with the same pride on the advertising content of our JOURNAL as we do on its scientific content. There may be room for argument when a product is rejected only because it has a trade name, but there certainly can be no argument when a product is rejected by the Council for failure to meet high scientific standards I do not doubt that the revenue from advertising would fall off if we adhered to the Council standards, but is

the increased revenue worth the sacrifice of scientific standards? Personally, I think not. Legislative problems are always with us, and doubtless we shall have the usual number this year We are constantly beset to effect a compromise on the chiropractic situation If chiropractic is based on a fraudulent theory, and we believe it is, we should certainly be lowering ourselves to stoop to compromise on a matter of principle. A special committee report is forthcoming on the whole subject of cult practice which will clarify the matter of cult practice and the often-debated basic science law

Dr Mitchell's Committee on Public Health and Education, with its numerous subcommittees, under his able leadership, continues to grow in effectiveness and progressiveness. It is impossible to place too high a valuation on the work of this committee

for the Society and its members

Since the last meeting of the House, a new State Health Commissioner has been appointed, Dr Herman E Hilleboe Dr Hilleboe has been most cooperative with the State Society and the same cordial relationships with the State Health Department that existed when Dr Godfrey was Com-

missioner are being continued.

Our Public Relations Bureau continues to do effective work, and its publications receive wide notice and approval This Bureau is helping to set up Speakers' Bureaus in the different county societies and to impress on these societies the importance of their being active in furthering good public relations and in educating the public Great credit is due Dr Floyd S Winslow, Mr Dwight Anderson, and Mr Thomas E Walsh.

The office administration has been placed on a sounder business basis. Our finances are in good condition. While we had a deficit for 1947, this was due, in part, to increased activities and, largely, to decreased income because of remissions of dues for military service. The amount to be remitted in 1948 will be much less and the recent increase in dues authorized by the House last May will ease the

financial strain.

In attending the meetings of the eight District Branches, I was impressed by the important part these play upstate They are of less importance these play upstate They are of less importance downstate where there is so much competition with other meetings It is my opinion that the Branches should not be disbanded, but that, perhaps, a different type of meeting should be arranged for those which include large cities, with more stress laid on the economic and legislative side of medicine. With the increasing tasks laid upon the President,

the position entails more and more time in the serv-

ice of the Society This load could be eased a little by a new arrangement with the District Branches. To attend all eight meetings in a single year requires not only a great deal of time but involves difficulties During the past season it in meeting the schodule was necessary to drive all night in order to be present at one meeting I would like to suggest that in the future the President attend four District Branch meetings and the President-Elect the other four When the President-Elect becomes President he should attend the four he did not attend as President Elect. In that way he would cover all eight Branches in two years instead of in one and it would be considerably easier for him No President would like to suggest this for himself, but I have no hesi tancy in suggesting it for my successors

Workmen's Compensation is covered in another report. There has been a good deal of diseatisfaction expressed over the new fee schedule but final decision has not been reached at this writing and it is hoped a satisfactory solution will be found. The special advisory committee, under the chair manship of Dr. Nathan B. Van Litten has worked

many hours on this difficult problem

Our Convitution and Bylaws provide that in case the death of the President the President-Elect shall become President serve the balance of that term, and then serve one of his own Due to the unitarity and then serve one of his own Due to the unitarity and then serve one of his own Due to the unitarity and the serve of the Amala Meeting We hope we shall never be so unfortunate again as to lose a President, but it can happen Also it out happen very early in his term so that the President Elect might have to serve nearly two years. Know ting by personal experience the responsibility, and work the office entails, it is my opinion that such a period is too long I suggest therefore that an amendment be considered by the House to the effect that if the President dies during the first six months of his term, the President Elect serve out that term and then retire, a new President being elected to serve the following year. If the President ides dur

ing the second six months of his term then the Presi dent-Elect should serve out the unexpired term and also one of his own. Even that would be a long time but to change a President after less than six months would be to confusing

Last year I offered an amondment to increase the size of the Board of Trustees to nine, and to provide that no member could serve more than two terms. It is still my opinion that this would be a beneficial move. While our Board of Trustees is and always has been, very able and conscientious, it is my opinion that the finances of the Society warrant a larger body for their management. Likwise, in order to encourage younger men to become active in the Society a limit on the tenure of office is advisable.

During the past year we have finally moved into more commodious quarters and this will make for greater efficiency all around Prior to the move, every department was overcrowded and two depart

ments were even on a different floor

No one could hold this office of President without being duly appreciative of those in the administrative office and the bureaus of the Society Mr Anderson Mr Farrell Dr Kaliski and Miss Dougherty have all been most cooperative and helpful To Dr Anderton I cannot begin to express my appreciation for the help he has given me and the many tasks he has taken off my shoulders. Quiet and unassuming, he is a tower of strength to the Society and a bulwark to the President.

The many committees of the Society are deserving of gratitude for the work they have done and are doing. I wish to extend my thanks to them also

Finally to the members of the House I wish again to express my appreciation of the great honor you conferred on me two years ago in electing me to the office of President It has been a rare privilege to serve you.

Respectfully submitted

LOUIS IL BAUER, M.D. President

Report of the Secretary

To the House of Delegates Gentleman

Membership—Elected in 1917 were I 542 new members 129 were reinstated. The net increase for the year as shown below was 779

we ruse your sea should below	WUS //9	
Membership-1946	20 524	
New members—1947	1 542	
Reinstated members-1947	129	22 195
Deaths-1947	253	
Resignations-1947	426	
Licenses revolved-1947	6	685
	_	21 510
1917 delinquent members		207
Total membership-1947	7	21 303
82 members are in the servi	co of our coun	try

Honor counties (none of whose members failed of their dues in 1947) include Cayuga, Chemung, Clinton, Columbia, Dutchess Essex Groene, Lewis Livingston, Orango Putnam, Richmond, Schuyler Schucea Tioga Tompkins, Warren Wayne, Wyoming, and Vates. Comparative totals of membership since 1936 follow

OHOW				
1936		14 662	1042	18 313
1937		15 520	1043	18,652
1938		16 177	1044	18 041
1939		10 785	1915	19 234
1940	,	17 409	1916	20 524
10.11		17 721	10.17	21 803

Publications —The 1947 Medical Directory of New York \(^1\) ew Jerrey and Connecticut was distributed in the late summer and early fall \(^1\) Owing to the fact that this was our first Directory since 1942 and as it included many physicians recently returned from service with the armed forces quite a number of errors appeared. However the Publication Committee has every reason to expect very few mistakes in the next issue which is now in preparation

The NEW YORK STATE JOURNAL OF MEDICINE has continued to improve its reputation both for edi-

torials and scientific content The Editorial Board,

under the able management of Dr George W Kosmak, is ever alert to improve your Journal Council —Immediately after the adjournment of this House last May, the Council organized At the June meeting, all matters referred to it from this House were presented by your Secretary who subsequently helped route them to Council Com-These matters are reported to this House in various parts of the Annual Report of the Council

During the past year, after nomination by the Council, Dr O W H Mitchell was appointed a member of the New York State Joint Hospital Survey and Planning Commission The Council nominated Dr. Harold R. Merwath for membership on the State Board of Psychiatric Examiners, Dr. Kenneth Horton, to be a member of the New York State High School Athletic Protection Plan, Inc, and Dr Albert F R Andresen to the Advisory Commission of the New York State Institute of Applied Arts and Sciences

The conference room in the new quarters of your Society, on the seventh floor of 292 Madison Avenue, New York City, was placed at the disposal of the Committee on Nursing of the House of Delegates of the American Medical Association, and at the disposal of the Economics Committee of the Coordinating Council of the Five Metropolitan County Societies It has also been used for meetings of the Board of Directors of the Physicians' Home, Inc.

Last December, as the result of a request from Dr Herman E Hilleboe, New York State Commissioner of Health, the Subcommittee on Industrial Health of the Committee on Public Health and Education had its function and name changed, to be known now as the Subcommittee on Industrial Health and Accident Prevention A Subcommittee on Nutrition was also created at Dr. Hilleboe's This Committee has acted in an advisory capacity to the Commissioner

On November 13, 1947, at the request of Dr Joseph J Witt, Chairman of the Session on Chest Diseases of the Medical Society of the State of New York, the Council voted to recommend that this House of Delegates create a Section on Chest thereby dissolving the corresponding A Section has two meetings during our Session Annual Meeting, whereas a Session meets only Also, a Section is entitled annually to elect a Chairman, a Secretary, and its delegate to be a member of this House [See Bylaws, Chapter XII, Section 1 and Section 3, and Chapter II, Section 1 (d)]

Also during the past year, the Council invited the

American Medical Association House of Delegates to hold its 1948 interim session in New York City This was declined in favor of St. Louis, Missouri However, an invitation for the 1949 interim session has not yet been acted upon by the Trustees of the American Medical Association Your Council also invited the American College of Physicians to meet in New York City in 1949, during the presidency of your fellow member, Dr Walter W Palmer Directives from the House of Delegates to the

Council are reported under the heading, "Résumé of Instructions of the 1947 House of Delegates and Actions Thereon of the Council, Board of Trustees,

and Officers'

Comments - Your Secretary has enjoyed the performance of his prescribed duties during the past The nominations for Affiliate Fellowship in the American Medical Association which you directed were so made Committee and Board meetings of the Council and Board of Trustees have been regularly attended, as well as seven of the eight District Branch meetings. Your Secretary attended the Annual Meeting of State Society Secretaries and Editors in Chicago, November 7 and 8, 1947, the New York State Health Department 43rd Annual Conference in Saratoga last July, the two meetings of the Middle Atlantic States Regional Conference on Medical Service of the American Medical Association, in Philadelphia, two hearings of the New York State Legislature Commission on the Advisability of a New York State University, in Albany, and the Annual Meeting of our County Society Secretaries, as well as the Annual Meeting of the County Legislative Committee Chairmen

Your Secretary, was delegated by the Council, with Dr J Stanley Kenney, to represent our Society at the Annual Meetings of the Medical Society of New Jersey, the Medical Society of the State of Pennsylvania, and the Connecticut State Medical He served with Dr Nathan B Etten on the Advisory Committee on Workmen's Compensation Law Minimum Fee Schedule, appointed by Miss Mary Donlon, chairman, Workmen's Compensation Board, State Department of

Labor

It has been possible for your Secretary to assist a number of physicians to find locations for practice, and, during his vacation, your Secretary enjoyed visiting Honeoye, Device, and Parishville, whence had come requests for physicians. It is with pleasure that your Secretary reports having attended both the Annual and Interim Sessions of the House of Delegates of the American Medical Our State Society was ably repre-Association sented at these meetings where your delegates presented matters about which they had been instructed Several of the delegates were on important Reference Committees, and at the June meeting, Dr Thomas A McGoldrick was elected vice-president of the American Medical Association Dr Floyd S Winslow was chosen by your delegation to be its Chairman, and he helped with his usual tactful leadership to continue the harmonious and united efforts of your delegation

It grieves me to report officially to you the death on October 10, 1947, of Dr Frederic E Sondern, past-president of our Society Proper notice was taken by the Council, and a memorial article approach to the Council of the Council peared in the New York State Journal of Medi-

Words cannot express properly my personal appreciation for the kind cooperation and consideration during the past year which have been shown me by my fellow officers, the Councilors, Trustees, and members of the staff of the Medical Society of the State of New York. The enjoyment of my work has been made fruitful by those with whom I have been associated

> Respectfully submitted, W P ANDERTON, M D, Secretary

Report of the Board of Trustees

To the House of Delegates Gentlemen.

This report covers the period from May 7 1947 to February 12, 1948 and will be published in the JOURNAL before the Annual Meeting in May A supplemental report to cover the period from February 12 to May 17 will be presented at the meeting of the House of Delegates

Meetings of the Board of Trustees were held on May 7 June 19 September 11 October 9 November 3 (special meeting) November 12, and December 11 1947, and January 15 and February 12 1948 The Board of Trustees was fortunate in the re-election by the House of Dalegates of Dr Edward R Cunnific and Dr James F Rooney to its member ship, as these men have had wide experience as former members of the Board and have previously rendered very valuable services.

This past year has been the most expensive year in the State Society's history This was due to an increase in the salaries and wages moving from the 21st to the 7th floor at 292 Madison Avenue with remodeling of those quarters purchase of new equipment and increased rent. Also we have had a deficit due to publication of the *Directory* and there have been increased costs in the functioning of some of the committees. Since the increase in dues did not go into effect until after January 1, 1948, most benefits from this revenue will not be felt until later

The House of Delegates in 1947 had before it cor tain recommendations of the Board of Trustees per taining to the formation of a Committee on Committees to have as its function an evaluation of all the committees of the Society in regard to overlapping of functions, efficiency expense etc. The Reference Committee recommended approval of the principles of conducting the management and ad ministrative affairs of the Society in the most effici ent manner possible. It recommended that the House of Delegates refer the matter to the Council the constituted committees and the Board of Trustees for study and such action as might be deemed appropriate. The Reference Committee report was approved by the House of Delegates The Board of Trustees, in conjunction with the Council has endeavored in every way to carry out the directives of the House in relation to the management of the financial affairs of the Society in the most efficient manner

The War Memorial is undergoing study by a special committee of the Council and the Board of Trustees and the findings of this committee will be reported to the House of Delegates for its consider

The recommendation of the Publication Committee that the subscription price of the JOURNAL be increa ed to \$5 from \$2 and that allocation of \$2.50 from dues be made for the JOURNAL, instead of the \$1 previously allotted, was approved by the Board of Trustees.

Contracts with Dr Kaliski Dr Hannon, and Mr Farrell were renewed as recommended by the Coun cil. These renewals were at the following rates Dr Kaliski from 311 000 to \$12,000 Dr Hannon from \$10 000 to \$11 000 and Mr Farrell from \$7,-700 to \$9 000

Fire insurance on the State Society's property at 292 Madison Avenue was increased from \$10 000 to This increase is in conformity with the present trend of insurance and is also advisable be-

cause of the increased equipment, etc.

The details of the finances of the Society will be covered by the Treasurer's report. However, the Trustees can report that the investments of the Society are in good order The total of securities held by the Society amounts to \$470 117 approxi mate market value as of December 31, 1947, with an approximate annual income of \$15 638. By judi clous changes made in investments during the past year the value of our investment portfolio was in creased and the quality of the portfolio was im-

The Trustees have approved the budget as submitted on a month to month basis to date

In order to meet obligations it was necessary on December 17 1947, to borrow \$50 000 from the Chase National Bank on a demand note putting up Chase National Bank on a demand now partial collateral in the form of assets of the Society at a rate of 14 per cent, which is the base rate. This note will be paid off as soon as incoming dues war rant such payment.

After due consideration and careful study by a committee of the Board of Trustees, the Trustees have entered into a contract with Patterson and Ridgeway, Auditors, to audit the books of the Medical Society of the State of New York. They were the lowest bidders and their firm is well recommended and bears a reputation of being reli able

An extrabudgetary appropriation of \$4,008 40 was made by the Trustees for the purchase of an addressograph, since the old one was beyond repair and a new one was needed urgently

The Trustees have heard much discussion in the matter of Malpractice Defense Insurance but have taken no definite action since the Trustees have no power to set policy

Respectfully submitted William H. Ross M.D. John J. Masterson M.D. EDWARD R. CUNNIFFE, M.D. JAMES F. ROONEY, M.D. ALBERT A. GARTNER M D. Chairman

Report of the Council

To the House of Delegates, Gentlemen

Your Council has the honor to report on the executive and administrative affairs of the Society in the period following your last meeting, May 5 to 9, 1947. The various matters that came before it, actions thereon, and recommendations, are here presented

PART I

Postgraduate Medical Education

The Council Committee on Public Health and Education has the following membership

O W H Mitchell, M D, Chairman Syracuse George Baehr, M D New York Charles D Post, M D Syracuse

Adviser

Herman E Hilleboe, M D , Commissioner, New York State Department of Health, Albany

The Council Committee on Public Health and Education arranges for instruction in a wide variety of subjects. Speakers are provided by the Committee for meetings of county medical societies, hospital staffs, and other medical groups. This program is made available through the combined efforts of the faculties of the medical schools and research institutions in New York State, the New York State Department of Health, the Dental Society of the State of New York, the Division of Industrial Hygiene and Safety Standards of the New York State Department of Labor, the Medical Society of the State of New York, and several other organizations and associations.

For programs arranged by the Committee, the Medical Society of the State of New York pays the traveling expenses of the speakers and the New York State Department of Health pays the honoraria for all speakers

The Committee prepares and distributes the Course Outline Book which lists subjects and speakers available. A new edition of the book will be ready for distribution in June, 1948, and will be mailed to the officers and chairmen of Committees on Public Health, Postgraduate Education and Program of the county medical societies, officers of the Medical Society of the State of New York, members of the House of Delegates, and to many other individuals and organizations

Copies of the 1946–1947 Course Outline Book have been mailed to the newly elected officers of the county medical societies for 1948, to the chairmen of the Committees on Public Health, Postgraduate Education and Program and to the Delegates from the various county medical societies to the Annual Meeting of the Medical Society of the State of New York in New York in May, 1948. With the book there was mailed the following announcement "The Committee is preparing a revision of the Course Outline Book. The 1947–1948 edition will probably be ready for distribution in June. Many changes will be made in keeping with the rapid advances and discoveries of modern medicine. If you do not find the desired subjects or speakers listed in the 1946–1947 issue, inform the Chairman, who will endeavor to comply with your requests."

On December 10, 1947, in New York City, the Council Committee on Public Health and Education held its annual conference to review the activities of

the Committee in the field of postgraduate education from May 1, 1947, to December 1, 1947, and to discuss plans for the coming year At the conference, material was distributed showing the number of lectures given, the percentage of attendance and the counties in which this instruction was presented The Committee expressed the appreciation of the Medical Society of the State of New York to the State Department of Health for not only the cooperation of the Department in the development of programs but also for the financial assistance received Present at this conference were The Deputy Commissioner of Health and several directors of the various divisions of the New York State Department of Health, the Director of the Division of Industrial Hygiene and Safety Standards of the New York State Department of Labor, members of the Council Committee on Public Health and Education, some of the chairmen of the Subcommittees of the Council Committee on Public Health and Education, and some of the officers of the Medical Society of the State of New York.

Arrangements for postgraduate instruction, presented as series of lectures or as single lectures on special subjects, were made for thirty-two county medical societies. The following counties have had

or will have had this instruction

COUNTY Broome	INSTRUCTION General Medicine	Number of LECTURES
Cayuga	General Medicine	б
Chenango	Poliomyelitis	1
Clinton	Treatment of Common Discases	7
Cortland	(General Medicine (Gynecology	4 1
Dutchess	Surgery	1
Franklin	Plasma Therapy	1
Fulton	Tuberculosis	1
Jefferson	General Medicine Obstetries Pediatries Surgery Cancer Neurology	2 1 1 1
Madison	General Medicine Surgery Pediatrics Gynecology Obstetrics Thoracic Surgery	3 1 1 1 1
Nassau	Rheumatic Fever Cancer Surgery Gynecology Tropical Medicine General Medicine Poliomy chitis Arteriosclerosis and Aging	1 1 1 1 2 4 1

(Gypeoology

Behoharie

(Concert Medicina

	General Medicine	2	Seneca	Chanconoga	i	
Oncida	Rheumatic Fever-	3		Surgery	1	
	Sympo-ium	٠				
			Steuben	General Medicine	1	
Onondaga (Syra	18urgery	1	Dicaboa	Central Academic	-	
cure Academy	General Medicine	î				
of Medi Ipe)	1000000	-		(General Medicine	2	
C. 21. L. 120,			Suffolk	Burgery	ī	
	Dermatology	1				
	Pediatrics	1		General Medicine	1	
Ontario (Geneva	Traumatic Surgery	1		Surgery	ī 1	
Academy of		1	Sullivan	Meningitis		
Medicine)	Oynecology	1		Plasma Therapy	1	
	(Surgery			(Gynecology	0	
Orange	General Medicine	3	Tioga	General Medicine	1	
	(0 111 1 1			(General Medicine	•	
•	(General Medicine	2 1	Tompkins	Neuropsychiatry	2 1	
Oswego	Gynecology Orthopedics	i	1 ompkim	Gypecology	i	
	Traumatle Burgery	;		(cr) pecology	-	
	(I taducatio built-1)	•				
			Ulater	Surgery Physiology	1	
Oteogo	General Medicine	2	Один	Physiology	1	
(With Delaware						
County)	General Medicine	1				
			Warren	General Medicine	2	
	(General Medicine	7				
	Dermatology			(Proctology	1	
Rlehmond	Neurology	1 1 1	Wayne	Surgery	î	
111021110114	Perchiatry	i		(_	
	Traumatle Surgery	1				
	Caneer	1	D!1	35	D	
	•			Meetings and Teaching		
				tings invitations are sent		
Rockland	Traumatic Surgery	1	bers of the medical societies in counties adjacent to			
				the instruction is given o		
	(Obstetrice	q		in regions and districts wh		
	General Medicine					
St. Lawrence	Pediatries	ī		ings are held. The Committee will arrange f		
Ct. IMarches	Cancer	2 2 1 1	speakers and for printing and distribution of pro-			
	Neurology	1	grams to m	edical societies medical	schools hos-	
	• • • • • • • • • • • • • • • • • • • •			EN YORK STATE JOURNAL		
Earators	Ri cumatic Fever	1		of the American Medical As		
	10	5		of Public Relations of the		
Schenectady	General Medicine	î		State of New York for publ	lication in the	
exchence(FG)	S irgery Cancer	i	local newspapers			
	Cancer	•		ing is a list of counties wi	hero Regional	
			Martines	The saline Door have I	1-14 414-	

Number of LECTURES INSTRUCTION REGION COUNTY Broome Chemung C rtland Chemango Otyego Schuy-le and Tioga Cancer* 3 Broome General Medicine Cancer* Monro (Not regional) (Not regional)

Ki gs. Queens. Nassau. and
Suffolk

Columbia. Renseel er. Saratogat. Sch. ne tady. and Renseelas Industrial Health toga, Sch (Not regional) Kidney Diseases

vear

As of February 28 1018 the Committee has ar ranged for postgraduate instruction for thirty five counties with a total of one hundred fifty-ax lectures In addition a request for three postgraduate lec-

Arteriosclerosis and

Aglog

Suffolk (Mather Memorial Hosp tal Staff)

tures has been received from the Nassau County Medical Society and arrangements are being made. A request also has been received from the Genesce

County Medical Society for a Teaching Day to be held on April 21 1948 in Rochester This will consist of five lectures The memberships of Orleans Wyoming and Livingston county medical societies will be invited to attend the meeting.

The Council Committee on Public Health and Education is arranging a Teaching Day to be held at the time of the Annual Meeting of the Medical Society of the State of New York on Tuesday May 18, 1948.

Meetings or Teaching Days have been held this

Subjects will be chosen which will not con-flict with the Scientific Section and Session programs to be held on Wednesday Thursday and Friday May 19 20 and 21 1948 This program will con-Therefore as of February sist of twelve speakers. Therefore as of February 28, 1948, provision has been made for one hundred seventy-six lectures

^{*} Traveling expenses, honoraria of speakers and printing of programs provided by the New York State Department of Health.

PART II

Maternal and Child Welfare

Maternal Welfare - Members of the Subcommittee on Maternal Welfare attended a meeting of the Committee on Child Welfare and the Council Committee on Public Health and Education held on October 21, 1947, in New York City For a report of these activities see the report of the Subcommittee on Child Welfare

The Subcommittee on Maternal Welfare has the

following membership

Charles A Gordon, M D, Chairman Brooklyn Paul W Beaven, M D Rochester Edward C Hughes, M D Syracuse James K Quiglev, M D Rochester

Regional Chairmen in Obstetrics

New York, Richmond, Bronx Counties George W Kosmak, M D, 23 East 93rd Street, New York City

Kings, Queens, Nassau, Suffolk Counties Harvey B Matthews, MD, 162 Chnton Street, Brooklyn

Westchester, Rockland, Dutchess, Putnam, 3 Orange Counties

Julian Hawthorne, M.D., Highland Hall Apartment, 131 Purchase Street, Rye

Schenectady, Fulton, Montgomery, Schoharie, Greene, Ulster Counties
William M Mallia, M D, 1364 Union
Street, Schenectady

Albany, Washington, Saratoga, Columbia, Warren, Rensselaer Counties Joseph O'C Kiernan, M D, 496 Madison

Avenue, Albany Chnton, Essex, Franklin, St Lawrence

Counties Edwin W Sartwell, M D, 14 Brinkerhoff

Street, Plattsburg Jefferson, Lewis, Herkimer, Hamilton Coun-

Wendell D George, M D, 203 Trust Company Building, Watertown
Onondaga, Oswego, Oneida, Madison, Cortland, Cayuga Counties

Edward C Hughes, M D, 713 East Gene-

see Street, Syracuse Broome, Tioga, Chenango, Otsego, Delaware, Sullivan Counties Stuart B Blakely, M D, 140 Chapin

Street, Binghamton

Monroe, Orleans, Wayne, Livingston, On-tario, Yates, Seneca Counties Ward L Ekas, M D , 176 South Goodman 10 Street, Rochester

11 Chemung, Schuyler, Steuben, Tompkins, Allegany Counties

R Scott Howland, M D, 531 West Water Street, Elmira

Erie, Niagara, Chautauqua, Cattaraugus, Genesee, Wyoming Counties 12

Lewis F McLean, M D, 826 West Delavan Avenue, Buffalo

Child Welfare —At the request of the New York State Department of Health, a meeting of the Sub-committees on Maternal and Child Welfare was held in New York City on October 21, 1947 Members of the Council Committee on Public Health and Education, some of the officers of the Medical Society of the State of New York and representatives of the State Department of Health were also present

At this meeting the statement prepared by the New York State Department of Health regarding proposed pediatric consultation services was considered, as was the plan of the Department to have obstetric films available for postgraduate medical education

On November 12, 1947, a meeting of the Subcommittee on Child Welfare was held with members of the Council Committee on Public Health and Education, some of the officers of the Medical Society of the State of New York and representatives of the State Department of Health At this meeting the following statement prepared by the New York State Department of Health was approved by the Committees

Statement Regarding Proposed Pediatric Consultation Services

The Medical Society of the State of New York and the New York State Department of Health agree on the principle that adequate pediatric consultation services should be available to general practitioners Such pediatric consultation services are primarily a technic of graduate education which will, in the long run, improve the quality of medical care to all the children of the State As such it is of concern to the two organizations issuing this statement

Private practitioners should be encouraged to make greater use of pediatric consultation serv-For patients who cannot obtain the needed consultation services, including indicated laboratory and \-ray examinations, such services should be made available to general practitioners through the instrumentality of the public health program on a regional basis radiating from a pediatric center Inasmuch as technics for providing such services have not been developed in detail, it is proposed that a pediatric consultation program be instituted in a single region of the State on an evperimental basis. The Buffalo region has been selected for this experiment

In the development of pediatric consultation services, major emphasis should be placed upon consultations for groups of patients in such locations that the needed laboratory and \ray examinations may be readily provided The referaminations may be readily provided ring physician is required and other physicians are encouraged to attend the group consultation In connection with such group consultations, teaching conferences and other educational devices should be arranged for the pediatric consultant In view of the varying circumstances in each case, the referring physician must be the individual to determine if pediatric consultation service, including indicated laboratory and x-ray examinations, is otherwise available to his patient

Individual consultations by pediatricians have been provided to a limited extent as part of the public health program for many years No change in policy in this regard is proposed

At this meeting qualifications and duties of consultant obstetrician and consultant pediatrician of the Division of Maternal and Child Health of the New York State Department of Health were considered, and the Committees will assist the Department in finding specialists to fill these positions

At the request of the New York State Department of Health, a meeting of the Subcommittee on Child Welfare was held in New York City on January 14, 1948 The Baby Book, a publication of the New York State Department of Health, was reviewed and the Committees made suggestions for changes

Department will include the following paragraph in the section on Acknowledgments" at the end of the book

The Council Committee on Public Health and Education, the Subcommittee on Child Welfare. and other representatives of the Medical Society of the State of New York have reviewed the Baby Book and made many valuable suggestions approved the use of the Baby Book for general public health education in New York State

Also present at this meeting were members of the Council Committee on Public Health and Education officers of the Medical Society of the State of New York and representatives of the New York State Department of Health

The Subcommittee on Child Welfare has the fol

lowing membership

Paul W Boaven, M.D Chairman Rochester Clement Silverman M D Vice-Chairman Вугасизе Brooklyn

Charles A Gordon M D Albert D Kasser M.D Rochester Alexander T Martin M D Now York City William J Orr, M D Buffalo Frederick H Wilke M D New York City

Regional Chairmen in Pediatrics (for regions comprising counties as shown in the list of Regional Chairmen in Obstetries)

Regions

- Harry Bakwin, M.D., 132 East 71st Street, New York City
- Charles A Weymuller M D 85 Pierrepont Street, Brooklyn
- Reginald A. Higgons M D 261 King Street, 3
- Port Chester James J York M D 930 State Street, Sche-4
- nectady Hugh F Leahy, M D 176 Washington 5
- Avenue, Albany Sidney Mitchell M D 71 Court Street
- Plattsburg
- Norman L Hawkins M D Woolworth Building, Watertown Brewater C Douat, M D 713 East Genesee
- Street Syracuse (To be appointed)
- Albert D Kaiser M D 729 Buckingham 10 Street, Rochester
- George R. Murphy M D 531 West Water 11 Street Elmira
- 12 William J Orr M D 333 Linwood Avenue Buffalo

PART III

Public Health Activities A

Industrial Health -The Study Committee on Industrial Health has the following membership

Leon H. Griggs, M.D., Chairman Stanley E. Alderson, M.D. Stuart A. Good. M.D. **Вутасиле** Albanı Buffalo Leonard Greenburg, M D David J Kaliski M D New York City New York City The Study Committee did not have a regular meeting during the year

The chairman attended the Eighth Annual Con gress on Industrial Health of the American Medical Association at Cleveland Ohio, on January 5 and 6 1948. Greater interest in industrial health is

needed with leadership centered in the Council on Industrial Health of the American Medical Association

The membership of the Study Committee will probably be increased to include two or three physicians giving special attention to accident prevention

Many of the lectures arranged by the Committee on Public Health and Education for county medical societies are a part of the Industrial Health Program. even though not so designated

A very successful Industrial Health Teaching Day was held in Troy New York, on December 11 1947 The memberships of the following county medical societies were invited to attend the meeting. Columbia Rensselaer Saratoga and Washington Rural Medical Service.—The Committee on

Rural Medical Service has the following member

Dan Mellen, M.D. Chairman Poter J. Di Natale, M.D. Edward P. Flood, M.D. Rome Batavia Bronx

There is interest in New York State in attracting physicians dentists and nurses into rural areas. With the new program of State and and State development of rural hospitals it is probable that such a program will be developed. The postgraduate departments of some of the medical colleges are now in the process of holding meetings with hospital superintendents to formulate a plan for the depart ment of medical service in rural and district communitles It is hoped that this can be worked out to the satisfaction of everyone concerned. Only a few rural communities in New York State are seeking aid in securing physicians and these requests are being handled through the office of the State Society

The dominant farm groups in this State are the Grange and the 4H We have had no communica tion from any of the agricultural colleges on their

programs.

As yet there are no definite health councils under the sponsorship of this Committee but communica tions have been made with groups along this line

The Hill-Burton program is progressing and we should have something interesting on this at an

early date

There has been no definite prepaid medical care plan through the State Society However for the past eight pears some of the medical and surgical care groups have cooperated with the federal Farm Security Administration and they have leaned money to their borrowers to enroll in a plan during the first year of membership This did not work out too well year of membership because many of the borrowers dropped out after the first year. They did enroll as long as they could borrow the money from the government but then made little offort to continue payments on their own

Hundreds of firms pay for the entire cost of the Hospital and Surgical Plan for all their employees. and allow a payroll deduction for the employees who desire to enroll members of their families as depend ents. However only a small percentage of rural areas profit by this plan since so few are now em ployed in industry

No definite plans or activities have been extended to rural areas for the improvement of health service This, however is being considered At the present time the rural problem in New York State is not a large one, because good roads have assisted the doc-tor and the patient in getting closer together The chairman of the Committee on Ruml Medical

Service attended the National Conference on Rural Health which was held in Chicago Illinois on Feb-

ruary 7 and 8 1048

PART IV

Public Health Activities B

Cancer — The Subcommittee on Cancer has the following membership

George C Adie, M D, Chairman New Rochelle Frank E Adair, M D New York City John S Fitzgerald, M D Utica Leo E Gibson, M D
William P Howard, M D
Victor C Jacobsen, M D
Louis C Kress, M D Syracuse Albany Troy Buffalo Clyde L Randall, M D Irwin E Siris, M D Buffalo Brooklyn

Meetings of the Subcommittee on Cancer were held on May 6, August 15, and October 17, 1947, to consider the cancer education program and the establishment of cancer detection centers Present at these conferences in addition to the Subcommittee members were members of the Council Committee of Public Health and Education, some of the officers of the Medical Society of the State of New York, representatives of the State Department of Health and Dr Frederick S Wetherell, of the New York State Division of the American Cancer Society

A report of the Subcommittee on Cancer was approved at the meeting of the Council on November 13, 1947, with instructions that it be sent to the secretaries of all county medical societies. Mimeographed copies of the report were prepared and sent to the secretaries of all county medical societies on December 18, 1947 The report is too long to appear here, and anyone desiring this report may receive it by making a request at the exhibit of the Medical Society of the State of New York at the Annual Meeting in May or by writing to the chairman of the Council Committee on Public Health and Education

Under date of December 1, 1947, the following communication was sent to the secretaries of county medical societies

Dear Doctor

Pear Doctor

Fellowships to further postgraduate education and training in fields related to cancer control are available to physicians of the upstate area. These fellowships up to three months duration, are open to physicians whose training would assist in the cancer control program in your county. Your aid is needed if these fellowships are to be used to the best possible advantage.

The fellowships carry a monthly stipend of \$300 payment of travel expenses and payment for tuition if necessary up to \$100 per month.

Physicians who wish to obtain training should make their own arrangements with the medical school or training center which they select. The fellowships may be used for short periods of observation at surgical clinics for training in radiation therapy for observation of well organized detection centers such as the Strang Clinic Memorial Rospital New York City for pathologic training in tumor diagnosis, in the Papanicolaou smear and other fields.

If you know of any physicians who desire this postgraduate training please have them contact the district health officer of the district in which your county is located.

Sincerely yours

(Signed) O W H. Mitchell M D Chairman, Council Committee on Public Health man, Council Cand Education

(Signed) Morton L Levin M D Assistant Commissioner for Medical Administration New York State Department of Health

At the request of the American Cancer Society one hundred copies of the Course Outline Book were supplied to them for distribution to their many state and local organizations.

Sixteen lectures on cancer have been given in seven counties, including two Regional Cancer Teaching Days For a report of these activities, see the report on Postgraduate Education These lectures, which are presented jointly by the Medical Society of the State of New York and the New York State Department of Health, have been well attended and received

BCG Immunization —The BCG Advisory Committee is an advisory committee to the State Department of Health and the Council Committee on Public Health and Education It has the following membership

Medical Society of the State of New York Milton I Levine, M.D., Chairman, New York City Edith M. Lincoln, M.D. New York City James R Reuling, M D Robert A Ullman, M D Bayside Buffalo

State Department of Health

Robert E Plunkett, M D Albany Konrad Birkhaug, M D Albany Gilbert Dalldorf, M D Albany Howard C Stewart, M D Albany

A meeting of the Advisory Committee on BCG Immunization was held in New York City on October 21, 1947, to consider suggestions regarding a few changes in the report of the BCG Program proposed publication, approved at the meeting of the Council on November 13, 1947, has been subjected to very careful study and will soon be published as a joint endeavor of the New York State Department of Health and the Medical Society of the State of New York.

Present at the meeting were members of the Council Committee on Public Health and Education, some of the officers of the Medical Society of the State of New York, and representatives of the New York State Department of Health

Hard of Hearing and the Deaf —The Subcommittee on Hard of Hearing and the Deaf has the following membership

Gordon D Hoople, M D, Chairman Syracuse C Stewart Nash, M D, Vice-Chairman, Roches-

Edmund P Fowler, M D Karl W Gruppe, M D Marvin F Jones, M D New York City Utica New York City Harry K Tebbutt, M D Albany

A meeting of the Subcommittee on Hard of Hearing and the Deaf was held in New York City on January 14, 1948 Members of the Council Committee on Public Health and Education and officers of the Medical Society of the State of New York were present, as were representatives of the State Departments of Health, Education, and Welfare. The problems of financing hearing centers throughout the State were discussed again In addition to existing centers, Buffalo is seriously considering forming a center, and Utica is also interested

A request for government funds to support this conservation of hearing program has been made, and further details will appear in the supplemental re-

The chairman of the Subcommittee on Hard of Hearing and the Deaf delivered an address at the 1947 annual meeting of the Medical Society of the State of New York on a proposed conservation of hearing program for New York State which outlined both the need and the possible solution for a hearing program

Mental Hygiene -The Subcommittee on Mental Hygiene has the following membership

S Bernard Wortis, M.D. Chairman Leslie A. Osborn, M.D. New York Buffalo Harry A Steekel M D Syracuso

Meetings of the Subcommittee on Mental Hy gione have been held on January 14 and February 11 1948, in New York City to consider the report "Some Aspects of the Problem of the New York State Mental Hospitals System by the Committee on Public Health Relations of the New York Acad emy of Medicine The report was approved al though there were some suggestions for a few minor changes and revisions.

The Subcommittee on Mental Hygicae prepared the following report which was approved by the Council Committee on Public Health and Education and the Council of the Medical Society of the State

of New York on February 12 1348

The Committee on Mental Hygiene of the Medical Society of the State of New York submits the following report with recommendations to the Council Committee on Public Health and Educa tion of the Medical Society of the State of New

lork.

It is apparent that the development of psychiatry and mental hygiene has gone for beyond the limited conception envisaged in the past by various individuals groups, and agencies comprehensive approach is necessary Present facilities for the care of pursons who are psychologically or mentally maladjusted or ill are made-quate in the State of New York There is great need for the establishment of psychiatric centers in connection with general hospitals also great need for expanding facilities providing mental hygiene clinic care.

We recommend that a Mental Health Council similar to the Public Health Council of the New York State Department of Health, be established as a part of the New York State Department of Mental Hymens. The members of the Mental Health Council should be persons cognizant of the broad fields of mental hygiene. The Council should represent the fields of psychiatry medicine

public health, psychiatric nursing psychiatric social work, and clinical psychology.

This Mantal Health Council should consist of the Commissioner of Mental Hymene and eight members hereinafter called the appointive members, to be appointed by the Governor of whom five at least should be physicians who are gradu ates of medical schools approved by the New York State Department of Education and licensed to practice medicine in the State of New York The Mental Health Council should not include appointive members who are in full time employ in the New York State Department of Mental Hy giene

Three of the members should be physicians who are recognized psychiatrists, at least one of whom is a prominent educator in the fields of psychiatry and mental hygiene one physician to represent the field of public health and qualified in this field, one physician actively engaged in the practice of medicine, a nurse registered in the State of Nev York and qualified in the field of psychiatric nurs-ing a graduate psychiatric social worker with clinical experience and a qualified psychologist cortified by the New York State Department of Mental Hyperne. Each of these members shall have had at least five years experience in his or her respective field.

The Committee on Mental Hygiene of the Medical Society of the State of New York urgently

requests that the Council pass a resolution to brang these suggestions to the attention of the Governor of the State of New York.

This report was approved by the Council of the Medical Society of the State of New York on Februnry 12 1918, and copies have been sent to Gover nor Thomas E Dewey and Dr Frederick Mac-Curdy Commissioner Sen York State Department of Mental Hygiene.

Rheumatic Fever -At the meeting of the Council on December 11 1947, the Chairman of the Council Committee on Public Health and Education stated

A proposal has arisen to give organized attention to rheumatic fover in this Committee. The Federal The Federal Government through the Children's Bureau, has a program and the State Department of Health also MS one Various foundations are financing studies The latest one has just on rheumatic heart disease been announced by the Masonic Lodge. There are approximately 275 000 Masons in the State of New York who probably will contribute. They have an advisory council to help them with their program. It is recommended that we have a Subcommittee on Rhoumatic Fever under the Public Health and Edu cation Committee to help advise on the rheumatic fever programs.

It was roled that this recommendation be adopted The President appointed the following physicians as members of the Subcommittee on Rheumatic

Frederick H Wilke, M.D Chairman New York Charles A. R. Connor M.D. Maurice J. Dattelbaum, M.D. New York City Brooklyn Clayton W Greene, M D Buffalo J G Fred Hiss M D Вутасиве Albert D Kaiser M D Rochester George M Wheatley M D New York City

This is an interlocking subcommittee with the Sub-committee on Child Welfare and other representa By such an arrangement there tives of the Society should be a broader understanding of the rheumatic fever program A meeting of the Subcommittee on Rheumatic Fever was held on January 14 There was general discussion of the many problems involved, and it is believed that this Subcommittee can be of valuable assistance to the many groups and agencies in advising and assisting the extensive plans now in operation or being developed in connection with this disease.

PART V

Public Health Activities C

Rehabilitation.—The Subcommittee on Rehabili tation has the following membership

O W II Mitchell M.D Chairman Бутасико Charles M Allaben M.D Albert F R Andresen, M Binghamton Brooklyn Conrad Berena, M D
Raymond E. Meek, M D
Raiph T B Todd M.D New York City New York City New York City Tarrytown

The same satisfactory relationship has continued throughout the year between the Medical Society of the State of New York and the various government been a considerable amount of correspondence but there is no report to submit regarding any change in policy or procedure

Genatrics —At the meeting of the Council of the Medical Society of the State of New York on June 19, 1947, Dr Louis H Bauer read a part of a letter received from Dr C Ward Crampton, under date of June 4, 1947

I suggested to Dr Mitchell that special interest in geriatrics on the part of the State Medical Society might be of service, and possibly it would be appropriate to appoint a committee or a subcommittee to put the matter forward in the medical field. He replied suggesting that I take the matter up with you, looking toward attention from the Council

As chairman of a Subcommittee on Geriatrics of the Public Health Committee of the New York County Medical Society, I endeavored to place the matter before the members of the local Medical Society through the columns of New York Medicine, May 20 I enclose a clipping there-

irom

In New York State the matter marches forward The reports of the Health Preparedness Commission, the State Commission on Aging, and the prospective organization of a new Joint Legislative Commission under Senator Desmond, which is on its way, all indicate interest and action

I hope the medical profession can take the leadership in this field. The interest of the phy-

sicians and the public is at stake

It was voted that this be referred to the Council Committee on Public Health and Education for study

On July 14, 1947, Dr Louis H Bauer tentatively appointed the following physicians as members of the Subcommittee on Geriatrics

Stephen R. Monteith, M. D., Chairman * Nyack Wardner D. Ayer, M. D. Syracuse C. Ward Crampton, M. D. New York City Scott Lord Smith, M. D. Poughkeepsie

These appointments were approved at the meet-

ing of the Council on September 11, 1947

On August 19, 1947, letters were sent to the deans of the medical schools in New York State inquiring if they were giving any special course or planned to give any in genatrics. Replies received indicated there were no definite courses in geratrics for undergraduates being offered at the medical schools throughout the State. The response indicated that they felt there was no definite need for such courses nor likelihood of their establishment.

The first meeting of the Subcommittee on Geriatrics was held on September 10, 1947, at the home of the chairman in Nyack Another meeting was held on November 19, 1947, in New York City Also present at these conferences were members of the Council Committee on Public Health and Education and some of the officers of the Medical

Society of the State of New York

On December 11, 1947, the first public hearing of the New York State Joint Legislative Committee on Problems of the Aging was held in New York City. The chairman of the Subcommittee on Genatrics presented a report at this hearing which was approved by the Council Committee on Public Health and Education and the Council. Anyone desiring a copy of this report may receive it by making a request at the exhibit of the Medical Society of the State of New York at the time of the Annual Meeting in May, or by writing to the chairman of the Council Committee on Public Health and Education

This report was favorably received

The Subcommittee is continuing its activities in close cooperation with the medical schools in the State of New York and the government and voluntary agencies giving attention to this most import-

ant medical and public health problem

There is increased interest in the subject of geriatrics, and more attention concerning the care of adult chronically ill, including special clinics and home care services, provision for postgraduate and research studies in medical schools, and participation of government and voluntary agencies in the establishment of institutions is being given to augment the program

Nutrition — The New York State Commissioner of Health, Dr Herman E Hilleboe, as Chairman of the New York State Food Commission appointed by Governor Dewey to cooperate with the National Food Conservation Program, requested the Medical Society of the State of New York to appoint a Subcommittee on Nutrition to cooperate with the New York State Commission

At the meeting of the Council on October 9, 1947, the following physicians appointed by Dr Louis H Bauer were approved as members of the Subcom-

mittee on Nutrition

Norman S Moore, M D , Chairman Ithaca Edgar C Beck, M D Buffalo Norman Jolliffe, M D New York City Elaine P Ralli, M D New York City

A meeting of the Subcommittee on Nutrition was held in Albany on November 28, 1947 There was discussion about the ways and means by which the medical group would be of assistance in the Food Commission program The following recommendations of the Subcommittee were presented to the Council on December 11, 1947, and approved

1 Support the creation of a Nutrition Bureau

in the State Department of Health

2 Support the plea to the curricula committees of the various medical schools of the State to introduce more subject matter concerning nutrition in medical education

3 Inform physicians of the State regarding recent advances concerning nutrition and stimulate

their interest

(a) Educational articles in the New York State Journal of Medicine, using as a guide the Handbook of the Food and Nutrition Board

(b) At annual meetings of medical societies work in special reports on the anthropologic aspects of nutrition in various cultures, and particularly our own culture, as a means of stimulating interest

(c) In the Council Committee on Public Health and Education include more programs on the

subject

(d) Disseminate information regarding the importance of nutrition in all age groups, to the specialists in obstetrics, pediatrics, and genatrics particularly, and stress the value of nutrition in all disease conditions

4 In cooperation with the State Health Department provide stipends for doctors who take advanced work in nutrition similar to the plans devaluated for special training in the capear program

veloped for special training in the cancer program 5 Support the State Health Department's request and the Food Commission's request for appropriations for research to be carried out at places where qualified nutrition clinics and educational facilities are available

Another meeting of the Subcommittee on Nu trition was held in Albany, on February 0, 1948 to consider the proposed program for the Bureau of Nutrition to be established in the State Department of Health This program was approved, subject to minor revisions, which have been made

Present at these conferences in addition to the Subcommittee members were members of the Council Committee on Public Health and Education some of the officers of the Medical Society of the State of New York and representatives of the New York State Department of Health

Physical Medicine.—At the meeting of the Council on June 19 1947, it was voted that the President be empowered to appoint a Subcommittee on Physical Medicine to consider the problem of the training and licensing of physiotheraputs in New York State This is a Joint Subcommittee of the Council Committees on Legislation and Public Health and Education

This Subcommittee on Physical Medicine has the

following membership

Charles M Allaben M D Charman Binghamton
John W Ghormley M D Albany
Kristian G Hansson, M D New York City
Richard Kovace, M D New York City
R. Plato Schwartz, M D Rochester
William B Snow M.D New York City

Meetings of the Subcommittee were held on September 16 and October 8 1947 in New York City to consider the qualifications and licensing of physiotherapists in New York State Present at these meetings in addition to the Subcommittee members were members of the Council Committee on Legislation and Public Health and Education some of the officers of the Medical Society of the State of New York, and representatives of the State Departments of Health and Education

As a result of these conferences a report with recommendations was prepared by the Subcommittee and submitted to the Council at a meeting on December 11 1947. The Council decided that further study should be given this matter. In the near future other conferences will be held in order to find, a satisfactory solution to the difficult prob-

lem of licensing physiotherapy technicians

PART VI

Economics

The Council Committee on Economics has the illowing membership

Pariton E. Wertz M.D. Chairman
Tharles M. Allaben M.D.
Binghamton
Rome

he Committee submits the following report

Pulic Medical Care

The Subcommittee on Public Medical Care has the flowing membership

Chtopher Wood, M.D. Chairman White Plains Carba D. Wertz M.D. Buffalo Chair F. Rourke M.D. Schenectady Howi P. Webb M.D. Utlea

Durik the past year with the exception of the summer on the subcommittee on Public Medical for has met with representatives of the State Detriment of Social Welfare at intervals of approximity six weeks. Also attending each of these meets were representatives of the New

Nork State Association of Public Welfare Officials and representatives of the medical consultants of various local medical plans in upstate New York and New York City As noted in last year s report, this entire group has been termed the Joint Committee.

Aluch of the work of the Subcommittee has conslated of consideration of minor details and a careful
review of innumerable problems attendant upon
the functioning of the local medical plans and the
relationships of the several personnel concerned. In
addition the tedious work of revising and rewriting
the Manual of the State Department of Social Wel
fare is progressing slowly. Many problems relating
to pharmacists optomotrists, drugs and appliances
have been referred to the Joint Committee for advice
and suggestions, and in some instances for decision
as to policy and procedure. A questionniare study
which elicited a very grafifying number of replies
indicated (1) that poor nutrition was not particularly
prevalent among welfare patients and was not a factor in prolonging hospitalization and (2) that
vitamins were prescribed frequently both as treat

ment and as a diet supplement

In order to avoid misunderstanding the Sub-committee desires to emphasize that its function is at a State level and of necessity its consideration of policies, procedures and problems must be at that level. Other than to advise or suggest it cannot intervene in local problems policies and procedures, these are the responsibility of the locality the local welfare commissioner and the county medical society. Every effort should be made to solve these problems locally, and to understand and evaluate the viewpoints and opinions of all those concerned in welfare work. Cooperation tolerance and goodwill at informal conferences, with the proper admixture of concellation and compromise almost invariably produce results. The presence of the medical consultant—of whom there are now 44—affords an excellent opportunity for lisiason between the local physicians and the local welfare administration.

The majority of complaints received by your Subcommittee voiced objection to the procedure of
payment to patients for medical services because
many patients did not forward these checks to their
physicians but, instead used the money for other
purposes. It has been stated that some welfare
clients call physicians unnecessarily in order to in
crease their regular allotments by the checks they
receive for payment of medical services. The State
Department of Social Welfare is quite willing to
pay physicians directly for their services but cannot
do so if the State is to receive rembursement from
the federal government as long as regulations of the
Federal Social Security Board require that pay
ments for medical services be made to welfare pa
tients, and not directly to physicians
At the present time the Joint Committee favors

At the present time the Joint Committee favors the recommendation that all groups concerned petition the Federal Social Security Board to change or void this regulation. The chairman of the Subcommittee is extremely doubtful of the wadom of this recommendation and urges very thoughful consideration before decision is made in its favor For reasons obvious to all of us, the medical profession has long insisted that no third party into vene botween doctor and patient. Payment of physicians directly would insure payment in overgase but it would reduce the patient's feeling of indebtedness and gratitude toward his doctor and all most certainly would make him feel irresponsible for and indifferent to payment for medical services

Because a number of welfare patients—just as a number of private patients—neglect or refuse to pay their medical bills, do we wish to implant in a further segment of our people the idea, or perhaps the conviction, that government is responsible for and pays for medical care? For this number of unpaid bills, or for the expedient of increasing our incomes somewhat, do we wish to abandon one of our most important principles?

The Subcommittee wishes to express its appreciation to all the members of the Joint Committee, without whose cooperation and advice much of the work could not have been done, and many of the ideas and suggestions would have been far less

thoroughly explored

PART VII

Medical Care Insurance

The Subcommittee on Medical Expense Insurance is composed of the following members

A H Aaron, M D, Chairman Leo F Simpson, M D Leo E Gibson, M D Buffalo Rochester Syracuse Frederick M Miller, Jr , M D Utica John E Heslin, M D Albany C Otto Lindbeck, M D Jamestown Abraham Koplowitz, M D Milton J Goodfriend, M D Brooklyn New York City Mrs Mary Madden, Liaison with Woman's Auxiliary Albany

The Committee has held two meetings, on April 4, and December 8 in New York City, for Committee members from New York City, Albany and Utica, and in Buffalo on December 15, for members from Buffalo, Rochester, Syracuse, and Jamestown

As no supplementary report was made in 1947 to the House of Delegates, your Committee takes the liberty of reporting on its activities since March

1.1947

At the April 4 meeting a progress report on earned premium, claim data, administrative costs, and surplus of the New York State plans for the year ended December 31, 1946, was distributed to those present Mr George P Farrell, director of the Bureau of Medical Care Insurance, explained in detail the statement on "Claim Data" and the formula used in determining reserves, in particular the reserve for maternity benefits All questions were answered satisfactorily by Mr Farrell

Mr Farrell reported on the difficulties encountered by the Western New York Medical Plan, Buffalo, due to high utilization in the general medical contract (including home and office calls) He stated that there was a surplus deficit on October 31, 1946, in the amount of \$47,183 Participating doctors contributed \$128,033 during the months of November and December to the Plan This contribution represented services rendered to members The Plan had a total surplus at December 31, 1946, in the amount of \$82,219

The Committee expressed its admiration of the manner and spirit in which this problem was handled by the underwriting doctors and voted that their action be commended in a report to the Council through the Council Committee on Eco-

nomics

The comprehensive medical contract (including home and office calls) was cancelled, effective March 1, 1947, giving an opportunity to contract holders to retain the original contract excluding home and office calls, but providing for medical calls while

hospitalized, or to change to the surgical contract. A projection of the Plan was presented and it seemed reasonable to assume that under the revised change the Plan would be able to continue on a sound underwriting basis. Since the revision of the contract benefits, the Plan has progressed on a sound financial basis, and at December 31, 1947, total surplus amounted to \$163,794 and, in addition, reserve for future maternity benefits increased during 1947 in the amount of \$40,762

Mr Farrell stressed the importance of quarterly reporting by the plans, stating that through progress reports prepared by the Bureau from figures submitted by the plans, similar difficulties in other plans could be detected and corrective measures taken

The Committee discussed again the question of affiliation of the plans in Associated Medical Care Plans, Inc. Mr. Farrell reported on a conference with Mr. Frank Smith, director of A.M. C.P., stating that plans approved by county medical societies but underwritten by commercial companies would not be considered eligible for membership. Mr. Farrell cited the advantages of affiliation in A.M. C.P., namely, information and statistics from member plans would be helpful in formulating policies, member plans would have a spokesman in the membership group, and early membership would enable members to learn how dues money was being used, public relations policies, etc. Following this meeting, several New York State plans have become members in A.M. C.P.

Mr Farrell advised the Committee that all plans have reciprocal privileges in the State and the Committee voted that compilation of the responses received from the plans regarding reciprocity be published in the New York State Journal of Medicine

At the sessions December 8 and 15, the following program for the 1947–1948 season was outlined

I Survey groups of doctors and subscribers in each plan to determine reactions to and experience in the plans

It was voted that Mr Farrell personally visit doctor groups and work through key personnel men for information on subscriber reaction, and compilation of information obtained to be prepared for the information of the Committee

2 Survey county medical societies in regard to approval of plan in each operating area

It was voted that Mr Farrell arrange an appearance before county society groups where approval has not been determined. A report of this survey will be presented at a later date

In connection with county society approval, Mr Farrell reported that Steuben County Medical Society had approved the Central New York Medical Plan, Syracuse, and that enrollment of doctors was proceeding Several doctors in Hornell, however, have already affiliated with the Western New York Plan, Buffalo, at a fee of \$10, and participation in Central New York requires a \$25 fee. In order that the Central New York Plan will have the participation of these doctors, it was recommended that arrangements be worked out between the two plans whereby doctors already affiliated with Western New York could participate in Central New York at a fee of \$15 instead of \$25, thereby making participation in both plans no more than \$25 This arrangement was to be presented to the Board of Directors of both plans for agreement

The Committee was advised that all areas are now served by a medical care plan with the exception

of one county

Publicize medical care plans locally through county society publications

It was roted to circularize county medical soclety publications and invite their cooperation by giving space to the plans operating in each area copy to be furnished by local plans and where needed, supplemented by the Bureau of Medical Care Insurance from the State level

Development of an informative folder for periodic distribution to doctors cost to be carned by each plan in proportion to the number desired

This project has been approved by all plans and the Committee voted to proceed in the preparation of such a folder early in 1018 Developments will be reported to the Committee at its next meeting

The Committee discussed the advisability of a uniform contract on a state level and recommended that further study be made Mr Farrell stated that inasmuch as all plans with the exception of Genesee Valley Medical Care Inc. Rochester have written an in-hospital medical-surgical contract this type of coverage would be the most logical on a State-wide basis It was brought out that in many instances enrollment was retarded because companies with branches throughout the State wanted coverage for all employees and for this reason it was urgent that further conferences and research be recommended and an early report submitted to the Committee

The Committee voted to lend its aid in misunder standings regarding disputes on claims and differ ences regarding policy between participating doctors and the plans. It was recommended that doctors be invited to submit such problems to the Com mittee for clarification and possible settlement.

Mr Farrell presented a brief verbal report on the progress of New York State plans for the year to September 30 1947, as follows Total membership 928 324 an increase of 327 000 increases by plans United Medical Service 256 000 Genesee Valley Medical Care 31 000, Northeastern New York Medical Care 31 000, Northeastern New York Medical Service, 15,000 Medical and Surgical Care 14 000, Western New York Medical Plan 6 000 and Central New York Medical Plan, 3 000 Claims incurred for the same period totalled \$2 578 000

The Committee recommends through the Council Committee on Economics that the Medical Society of the State of New York extend continued ap-proval of the six New York State plans for another year, as follows United Medical Service, Inc. New New York Genesso Valley Medical Care Inc Rochester Contral New York Medical Plan Syra Medical and Surgical Care Inc. Northeastern New York Medical Service Albany and Western New York Medical Plan Buffalo This recommendation is in accordance with the Standards of Acceptance for Approval

The Committee wishes to express its thanks to the officers of the Medical Society of the State of New York, and to Dr Carlton E Wertz chairman of the Council Committee on Economics, for their interest

and attendance at meetings

Bureau of Medical Care Insurance —The Bureau of Medical Care Insurance George P Farrell di rector reports as follows

The activities of the Bureau have been carried on under the direction of the Subcommittee on Medical Expense Insurance of the Council Committee on Economics

In the field of public relations, Mr Farrell has appeared before Woman's Auxiliary groups of the counties of Orange and Ulater the Port Jervis Com

munity Club an affiliate of the Federation of Women's Clubs two county medical society stated meetings, the Vermont Health Council and other civic organizations Mr Farrell has written and presented papers before these groups on the various aspects of voluntary prepaid medical care insurance He also has taken part in forums and debates, covering specifically the plans operating locally throughout the State Comments from many sources have shown that this type of publicity has increased enrollment and stimulated doctor interest in the plans.

On invitation of Dr O W II Mitchell chairman of the Council Committee on Public Health and Education of the Medical Society of the State of New York Mr Farrell has talked before two senior medical student groups of the Syracuse I inversity College of Medicine He presented a paper before the senior sociology class of Champlain College, cloung his appearances in that locality by taking part in a debate with Mr Francis Wilson Ph D, head of the biology department of Associated Colleges of Upper New York on the subject Resolved That socialized medicine should be instituted in the United States

At the request of the Industrial Council Mr Farrell took part in a discussion program with representatives of the Standard Oil Company of New Jersey on compulsory sickness insurance

As recommended by the Subcommittee on Medi cal Expense Insurance Mr Farrell has conferred with Mr Thomas Hendricks, of the Council on Medical Service of the A M A on the question of a seal of acceptance of medical care plans in New York State and with plan directors on the informative folder to be distributed to members by the plans

The director has held meetings with Dr Aaron chairman of the Subcommittee on Medical Expense Insurance on present and future activities of the Committee to be carried on by the Bureau

Mr Farrell was present at the First Second Third and Fourth District Branch meetings of the Modical Society of the State of New York, presenting a paper at the Fourth District meeting on The Present Status and Future of Medical Care Insur ance in New York State He has attended Subcommittee meetings Council meetings of the Medical Society of the State of New York, the second annual conference of Associated Medical Care Plans and the annual meeting of the American Modical Association Following the Annual Con-ference of A.M.C.P. Mr. Farrell prepared and distributed to members of the Council abstracts of the various A M.C P Committee reports He also attended the annual conference of Medical Society Secretaries at Albany hearings at Albany on legis-lative bills amending Article 9-c of the State Insurance Law

As a member of the liamon committee with Veter ans Administration he has been present at its meet ings and prepared comparative fee schedules for consideration and use of the Veterans Administra tion and Veterans Medical Service Plan of New lork Inc. in the program of home town care of veterans with service-connected disabilities

Mr Farrell was a guest of the United Medical Service activities at its annual dinner, where a report was read on the United Medical Service and a fifteen point program to improve medical care was outlined by Mr Bornard Baruch guest of honor Mr Farrell also attended the Middle Atlantic States Conference on Medical Service, at Philadelphia, spon sored by the Council on Medical Service of the A MA

On approval of the Council of the Medical Society of the State of New York, Mr Farrell is serving as a member of the new Committee on Research Sta-

tistics of A M C P

The results of the Committee's survey of county medical societies regarding approval of plans operating in their areas have been gratifying. Steuben County Medical Society has approved affiliation with the Central New York Medical Plan, Syracuse, and it was agreed by the Board of Directors of Central New York and Western New York plans, that a doctor, now participating in the Western New York Plan at a fee of \$10, could become a participating doctor in the Central New York Plan by payment of \$15, making the total fee for participation in both plans not to exceed the \$25 fee required by the Central New York Medical Plan During the past year the Jefferson County Medical Society has approved affiliation with Medical and Surgical Care, Inc., Utica, and services of that plan are now being offered to residents of Jefferson County

On the Committee's recommended program of publicizing medical care plans locally in county medical society publications, Mr Farrell reports that letters have been sent to the seventeen publications throughout the State and responses have

been favorable

The Committee's program to survey participating and nonparticipating doctors in the six plans, as well as subscribers throughout the State, to determine reaction and experience, has been started. This survey will aid the Committee to determine future activities, and it is the desire of the Committee that this program be completed as quickly as time will allow. It is hoped a report can be made at the Annual Meeting.

The Bureau has continued its policy of preparing and distributing to Subcommittee members, plan directors and executives, and the State of New York Insurance Department, quarterly progress reports on the New York State plans A report on the progress of the plans as of December 31, 1947

follows

Total membership (subscribers and dependents) as of December 31, 1947, was 1,023,615 Increase in enrollment during 1947 was 425,573 members, or 29 per cent over the previous year's enrollment

Following is a comparative membership statement of increase in the Blue Cross Hospital and Medical Care Plans in New York State for the year ending December 31, 1947

	Medical	Hospital
United Medical Service, New York Western New York Medical	325,001	417,191
Plan, Inc , Buffalo	19,427	24,574
Medical and Surgical Care, Inc, Utica	20,122	9,750
Central New York Medical Plan, Inc., Syracuse	4,014	22,486
Genesee Valley Medical Care, Inc, Rochester	34,231	23,057
Northeastern New York Medi- cal Service, Inc., Albany	22,778	36,666
TOTAL	425,573	533,724

Forty-four per cent of the combined membership increase was in medical plans as compared to 32 per cent in 1946. This gain is significant, because the total membership in medical care plans was 22 per cent of total Blue Cross membership as of December 31, 1947, as compared to 16 per cent December 31, 1946.

The medical care plans had an earned premium income during 1947 of \$5,908,744 and incurred claims amounted to \$3,681,557 Earned premium income during 1946 was \$3,100,444 and incurred

claims, \$2,009,869

The continued success of the New York State plans will depend upon the cooperation and support of the doctors. Approximately 75 per cent of all practicing doctors in the State are participating in the plans. In areas where doctor participation is close to 100 per cent, enrollment of members (subscribers and dependents) is increasing rapidly, but in a few areas where the majority of doctors do not participate, membership enrollment is definitely retarded.

The Bureau wishes to thank Dr Carlton E Wertz, chairman of the Council Committee on Economics, Dr Aaron, chairman, and the members of the Subcommittee on Medical Care Insurance of the Council Committee on Economics, the Public Relations Bureau, and the New York State Journal of Medicine for their cooperation and assistance

during the past year

Mr Farrell wishes to express his personal thanks to the Woman's Auxiliary groups for arranging programs on medical care insurance

PART VIII

War Memorial

The Committee on War Memorial of the Council and Board of Trustees has the following membership

James F Rooney, M D , Chairman
Edward R Cunniffe, M D
Maurice J Dattelbaum, M D
Fenwick Beekman, M D
New York City

The Committee had its first meeting on September 11, 1947, and decided that a factual study of the question would be required in order to arrive at the total number of the living children of former members of the Society who were killed in action or died in service during World War II, their sex, ages, the desires of their mother, guardian, next of kin or themselves as to the type of education they desired, the number of years that would be required for each of them to complete such education and, especially in the case of those above the age of 16, whether or not they desired to adopt a graduate college education as a preliminary to medical, legal, or other professional training, that the securing of these facts would be a necessary preliminary to conducting an actuarial study of the total expenditure that would probably be required on the part of the State Society, and the probable portion of these expenditures that would be required for each year until the education of these children had been completed, because it must be kept in mind that the ages of these children, as noted in the preliminary list which follows, extends from 7 months to 22 years, grouped by quinquennial periods, as may be noted in the This information, which was secured by summary the first questionnaire through the secretaries of all the county societies, is still somewhat incomplete as regards certain addresses, and no reply has been received to the questionnaire from the secretaries of two of the smaller county societies, and it is the opinion of the Committee that it may be reasonably inferred that these counties have no mortality among their members who were in the Armed Forces of the United States

The information shown in the list has only been completed within the past few weeks and a second

questionnaire a copy of which follows is now being sent to the widow the mother guardian or next of Lin of the children of the deceased mem bers of the Society in order to learn the present educational situation and plans for the future edu cation of these children

It will be quite apparent that until the replies to this second questionnaire are received it will be im possible to hazard anything but a rough guess as to the expense that would be entailed upon the Society by way of financing the advanced education of the children of its members who died during their service in the Armed Forces or consequent thereto as a result of service connected wounds or disease

The Committee therefore is submitting this preliminary report and hopes that it may have secured sufficient data prior to the 1948 Meeting of the House of Delegates that it will be in a position to give the House in a supplementary report, a preliminary estimate of the probable total expenditure of money that would be required to carry out the purpose of the resolution but the Committee is not at all sanguine that by the time of that meeting it will have had sufficient time to make an actuarial study of the data received which will have more than a remote approach to probable accuracy
It will at that time, in the supplementary report
submit its recommendations to the House

WAR MEMORIAL

County	Member and Guardian	Children	Ago
Albany	None		
Allegany	None		
Bronz	Captain Samuel W in Mrs. Frieda Wein, guardian	Mortimer Robert	?1 11
Brooms	None		
Cattarnugus	Dr. Clifford Schmeising Mrs. Clifford Schmeising, guardian	Clifford Sandra James Julie Ann Grace Ryan	10 11 0 8 5
Cayuga	None		
Chautauqua	Dr DeF rest W Buckmaster Mrs DeForest Buckmaster guardian	Joan Mary	22 19
Chemung	Dr Charles L. Stevens Mrs. Arl tto T. Stevens, guardian	Charles L Fayette M	18 16
Chenango	None		
Cilnton	Dr Victor F Krakes Mrs. Lorrella C Krakes, guardian	Joan Marie	3
Columbia	None		
Cortland	None		
Delaware	None		
Dutchess	Dr Bernard Welss Mrs. Miriam Welss guardian	Berne	5
Erie	Dr Gene W Hair	8on	2
Easex	None		
Franklia	Dr Bruce T Smith Mrs. Bruce T Smith guardian	Robert Bruce Douglas	16 10 3
Fulton	None		•
Geneses	None •		
Greene	None		
Herkimer	Non		
Jefferson	None		
Kings	Dr Louis Michaels Mrs. Ruth W Michaels guardian	David Seth	4
	Dr Raymond B Miles Mrs. Catharyn C Miles, guardian D Patrick B Haran Mrs. Lillian Haran, guardian Dr Loui P Kasman	Kay Vivian Raymond B., Jr William David Patricia Lillian Marie	11 9 8 20 16
	Dr Louis P. Kasman, guard-	Karen Riohard	11 10
	ian Dr Bamuel G Rosenfeld Mrs. 8 muel G Rosenfeld	Jeffry I	3
	guardian Dr Harold M Sachs Mrs, Harold M Sachs	Lawrence Marcia	°4 17
	guardian Dr W W Samuelson Mrs. W W Samuelson,	Carol Jeanne	6
	guardian Dr Thomas R. Turino Mrs. Thomas R. Turino guardian	Judith Hall Karen T	10 8

County	Member and Guardian	Children	Ages
Lewis	None		
Livingston	None		
Madison	None		
Monroe	Dr Joseph D Picciotti	Gemma	15
111011100	Mrs Catherine M Picciotti	Catherine A	13
	guardian	Josepha A Joseph D	11 10
Montgomory	None	vosepit D	-0
Montgomery Nassau	D. H. F. Ocango	Patricia Joan	8
v u s s u u	Mrs_Herbert Orange guardian	Richard Lawrence	8 6
	Dr J A Randazzo	Norsta Julia	8 6
	Mrs Alice Ottesen Randazzo guardian	Beatrice Joyce	
	Dr Joseph E Funk	Joseph	8 5
	Mrs James W Toote (for- merly Mrs Funk) guardian	Thomas Paul	5 4
		Sandra	11
New York	Dr Morns Horn Mrs Ruth C. Horn, guardian	Sandra	-
	Mrs Ruth C Horn guardian Dr Bruno Solby	Michael Arthur	10
	Mrs Trude D Solby guardian Dr Richard Benfield	John	15
	Mrs Lola Benfield guardian Dr A. Whitfield Hawkes	Stephen W	11
	A. W Hawkes grandfather	Frances Ann	9
	guardian	T: -11 T	12
	Dr Clyde H Brown Mrs Erva F Brown guardian	Franklin K	1-
Ningara	None		
Oneida	None		
Onondaga	Dr Paul H Lowry	Susan Jane (Married)	20
	Mrs Ralph Darran (formerly Mrs Lowry) guardian	•	•
Ontario	None		
Orange	None		
Orleans	None		
Oswego	Noanswer		
Otsego	None		
Putnam	Noanswer		
Queens	Dr Alfred L Lyons Mrs Evelyn Lyons, guardian	Arthur Edward Edith E	16 14
Rensselaer	None		
Richmond	None		
Rockland	Dr Henry A Silberstein	Judith	14 10
St. T	None	Peter	10
St Lawrence	None	Patan D	4
Saratoga	Dr Richard D Bullard Mrs Elizabeth Bullard	Peter D Thomas J	4
	guardian	(twins)	_
Schenectady	Dr Robert C Maxon	Robin	9 4
	Mrs Robert C Maxon guardian	Laurie	1
Schoharte	None		
Schuvler	None		
Seneca	None		
Steuben	None		
Suffolk	None		
Sullivan	None		
Tioga	None	•	
Tompkins	None		
Ulster	Dr Joseph George Sandler	Jane	10
	Mrs Joseph G Sandler guardian	Peter Richard	10 7 4
Warren	None	1000014	
Washington	None		
Wayne	Dr Edwin T Tellman	Joan	9 7
·· 	Mrs Edwin T Tellman guardian	Sally	7
Westchester	None		
Wyoming	None		
Yates	None		

	Summa	ıry	
Age Lears	Number	Boys	Girl
Under 5 6-10 11-15 16-20 Over 21 Totals	14 22 13 10 3 62	11 12 5 5 2 35	3 10 8 5 1 27

Letter and Ouestionnaire

The enclosed questionnaire is submitted by a Bubcommittee of the Council and the Board of Trustees of the Society in order to secure the actualist informati in necessary to devias a-plan for educational assistance to the children of formar members of the Society who were killed in action or who died of service-connected disability during World War II from September 15 1940 to date hereof Without this complete information it is improvible for the Subcommittee to make an estimate of the probable cost and feasibility of a Airmorial Finn order to make sentiality exceedings to the Society at its meeting in the spring of 1948.

with the Subcommittee in completing this questionnaire at the earliest possible moment and return it to:

Dr Walter P Anderton Secretary Medical Society of the State of New York 292 Madleon Avenue New York City 17

James F. Rooney, M.D., Chairman Edward R. Cunnifie M.D. Maurice J. Dattelbaum M.D. Fenwick Beckman M.D.

Navy

February 8,1948

Question naire

Submitted by the Subcommittee regarding the War Memorial of the Medical Society of the State of New York.

Name of father

2 Rank Army

> Coast Guard Public Health Service

Lilled in action died in service

- Date and piace of death, if known
- Date of entry into service
- Plan for future education, business

Profession

8. Surviving children

Present educational situation

	Namea	Sex	Prosent Age	Pre- sebool Grade	Private school Grade	Primary School Grade	Secondary School (High School) Grade	Professional School Graduate	Degrae
۸.							-		
В									
О. —									
D -									

Please furnish the Subcommittee with any additional information which you desire to bring to its attention especially such as present educational needs for the children, etc. and anything else which you feel may help the Subcommittee in accomplishing its purpose.

All information which you give in this questionnairs will be held as absolutely confidential by the Subcommittee Remarks:

Signed

PART IX

Legislation

The Council Committee on Legislation consists of the following members

Harry Aranow M.D., Chairman Walter W. Mott. M.D. Frederic W. Holcomb, M.D. Bronx White Plains Lingston

The Council Committee on Legislation has been requested to submit a report of its activities for publication. This request for an early report, which it is understood is necessary for publication before the meeting of the House of Delegates, will make it necessary that a supplementary report be made at a later date. The Legislature is in the middle of its ession at the time this report is made. The budget bills which have been introduced have not been cleared so far so action on many of the other bills has not progressed to any extent.

Up to February 15 there had been 1 729 bills introduced in the Senato and 1983 bills introduced in the Assembly We have reported to the officers of the State Society to the officers of the county societies, and to members of the county society legislative committees, concerning 68 bills in the Senate and 81 bills in the Assembly A number of these bills are concurrent that is, in both houses. Of the 08 Senate bills comes of 24 bills have been sent to the chairmen of the county society legislative committees Of the 81 Assembly bills 17 have been sent out This makes a total of 41 separate bills which we have had particular interest in following Very few of these bills are, however of such importance as to call for exceptionally strong representation for or against Of these bills, the ones that would seem to call for most important representation to the members of the Legislature are the chiropractic bill and the three bills introduced at the request of the State Society

A single chiropractic bill has been introduced up That bill is Assembly to the date of this report Int 713 (Noonan) It was introduced on January 21 and on February 9 was amended and recom-There has been no companion bill introduced in the Senate nor has the second chiropractic bill, which we have been anticipating, been introduced so far this year

The House of Delegates at its meeting last May requested that a bill be introduced that would amend the Workmen's Compensation Law by abolhas been introduced in the Senate by Senator Fino and is Senate Int 1341 It has also been introduced in the Assembly by Assemblyman Hanniford and is Assembly Int 1575 It is realized that this bill is not favored by the Department of Labor and, therefore, unless strong representation is made in support of this bill, it will not proceed

The second bill introduced at the request of the House of Delegates is Senate Int 1248 (Fino) This bill defines x-ray diagnosis as a method of medical practice and prohibits practice without license There have been many attempts to get a bill passed that would define x-ray as the practice of medicine The bill introduced this year, although not entirely satisfactory to all, was the result of It was decided at these conferences conferences that a bill, similar to the bill introduced by Assemblyman Clancy last year, should be introduced, retaining the section which permits the practice of x-ray by those professions now entitled to use x-ray and by persons, firms, associations, and corporations which have been engaged in such practice for a period of five years or more continuously, to continue such practice It was thought that the Legislature would be very hesitant to withdraw these privileges from those organizations which have been long established in such work. It was thought by the committee that the introduction of this bill, permitting the continuation of this practice but shutting off the establishment of future practice of this nature, would have a better chance of being enacted than a bill which would stop such practice by those so engaged at the present time. It was realized that there will be also great difficulty in obtaining the passage of this bill unless strong support is given it

The third bill introduced at the request of the State Society amends the Penal Law and would make the treating of the human body, without proper licensure, a misdemeanor This bill was proper licensure, a misdemeanor This bill was the result of studies made by members of the committees of the Council and members of the State Society's office in an attempt to find some way to strengthen the law in abolishing illegal practice The law against illegal practice is now under the Education Law, in the Medical Practice Act From that angle there is certain difficulty in obtaining convictions in the criminal courts, as the question arises in such procedures as to whether the act of the person being tried is the practice of medicine or not. It was thought by this amendment to the Penal Law that the question would only be whether the person had treated the human body and was licensed and registered for the giving of such treatment There are similar sections under the Penal Law in regard to the practice of pharmacy and veterinary medicine. The introduction of such a section in the Penal Law would in no way change the section under the Medical Practice Act It is hoped that this bill in the Education Law

will be enacted, but it is realized that it will take very strong support from members of the medical profession and their friends for such favorable ac-

It is regretted that we cannot give more definite information on many of the matters pertaining to legislation, but as the session is so young at the time of this report it is impossible to do so mentary report will be submitted after the close of the Legislature and the final action of the Governor on bills in which we are interested

PART X

Workmen's Compensation

The Council Committee on Workmen's Compensation, consisting of Dr J Stanley Kenney, Chairman, Dr Joseph P Henry, Dr Norman S Moore, submits the following report of the activities of the Committee and Workmen's Compensation Bureau for the past year A supplementary report will be submitted to the House of Delegates at its

Annual Meeting in May, 1948

County Society Workmen's Compensation Committees—In our last report, we referred to the employment of full or part-time executive, legal, and clerical help to operate the Workmen's Compensation Bureaus or Committees of the local county medical societies throughout the State In the smaller counties this function is carried out by voluntary committees assisted by the Secretary of the Society or by him in conjunction with the Comitia Minora serving as a compensation committee increase in the volume of compensation work with the attendant problems arising therefrom have placed increasing work on the committees which they have fulfilled in a commendable manner number of the larger county medical societies employ full or part-time executive and clerical help The smaller counties are financially unable to meet the expenses of such help, and sometimes the volume of work does not justify it However, the numerous problems arising in the course of the year are often of such importance or magnitude that they should be brought to the attention of our Workmen's Compensation Bureau

Greater efficiency and uniformity of action would also be assured by clearing such matters through the Workmen's Compensation Bureau It is also suggested that the interests of the profession would be better served and the solution of the various local problems facilitated if a number of adjacent county medical societies would combine and collectively set up an office to serve as a liaison between the pro-fession and the other interested parties This would fession and the other interested parties This would improve the functioning of our Workmen's Compensation Bureau and enable it to deal with the numerous State problems that arise more effectively Undoubtedly, as has and with greater dispatch been the case in the counties where such committees have already been set up, many of the minor dis-putes and misunderstandings between doctors and insurance carriers or employers could be resolved and also better relationships established between the profession and the employers and insurance carriers, enabling the profession better to serve the public These district groups could be set up on a pattern of the five large district branches of the Workmen's Compensation Board throughout the State or, perhaps better, on the basis of the district branches of the State Medical Society
Enlargment of Workmen's Compensation Com-

mittee -There is need for wider representation

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on the Workmen's Compensation Committee of the State Medical Society The Council Committee of Workmen a Compensation is limited to three members. The various parts of the State should have an opportunity to participate in the deliberations of this Committee.

It is recommended that there be an advisory committee representing the various parts of the State to consist of not more than five or eix physicians appointed by the president. We believe this will facilitate greatly the work of the Bureau and make it possible for the Bureau to keep in closer touch with the views of the memberahip throughout the State.

In the appointment of members to this Committee only those who have a genuine interest in and an understanding of the Workmen's Compensation

Law and its problems should be considered.

Physicians Reports.—The Workmon a Compensa tion Laws of the State have been liberalized year by year as far as benefits to the employe are concerned, while increasing costs to the employers and indirectly to the consumer The Workmen's Compensation Laws rightly provide liberal benefits in the case of death or disability from industrial accidents and occupational diseases. It is probably not appreclated how great a part the medical profession plays in the over-all picture of workmen a compensation not only in the medical care of injured workers, but in the adjudication and settlement of claims from the inception of the reported accident to the ultimate decision as to the compensability of a par ticular claim and the benefits to be accorded the in jured workman or his dependents It should be realized that the more efficient and skillful medical care is the less costly the compensation claim will be Every compensation claim is strictly scrutinized by the employers and insurance carriers to determine the liability of the employer so that the degree of promptness and accuracy, with which reports of accidents are filed, in a large measure determines the number of disputed claims requiring review by the Workmen's Compensation Board as to compensa bility Not only will prompt, accurate, and detailed reporting of accidents hasten the disposal of claims, but it will also serve to hasten the payments of disability claims to the injured worker. In the past year the law has been amended to make it unneces sary for a physician to notarize the C-4 form has lessened the burden of the physician to some ex tent The C-4 report being accepted as prima facie evidence of the material in the report, the more complete the report, the less often will a physican be called to testify before the referee or the Workmen s Compensation Board Since each claim is a quasilogal one the need for reporting can never be elimi nated, but the physician has it in his own hands to lessen his own burden and to hasten the administrative procedures incident to the settlement of claims

The physician s report if promptly mailed may be the first indication to the insurance carrier and to the Workmen's Componentian Board of an industrial accident or illness, and if sufficiently descriptive of the accident and the disability incurred it will go a long way to facilitate the speeding up of componential cities. Prompt reporting will also do away with complaints by insurance carriers and employers against physicians for failure to comply with the law on reporting and will facilitate the payment of doctor bills. Irksome as reporting is to a busy doctor, he must realize that it is impossible to administer effectively and promptly, the Workmen's Compensation Law without his full cooperation. Metionious attention to dotaits in reporting would also eliminate

many controversies and postponements of hearings on claims and would lesson the cost of administration to the employers and insurance carriers.

Better Medical Care to Injured Workers-Rehabilitation.—The advances in medical practice during the past decade have greatly reduced dangers of infection following accidents with the concomitant disability resulting therefrom. It has been and should continue to be the duty of the medical profession, through state county, and local medical societies, to encourage the application of the latest advances in medical practice to the treatment of compensation claimants. Every effort should be made to reduce the period of disability and while giving adequate medical care endeavor abould be made to return the patient to his work as soon as safely possible The physician should be alert to the possibilities of instituting rehabilitation and reconstructive measures at the earliest possible moment. There should also be greater discrimination in the application of physical thorapy measures, and the use of such measures should not be persisted in beyond the period of their maximum efficiency The too frequent use of these modalities after the acute stages greatly increases the cost of medical Experts in this field should be called upon more frequently to determine the need for such procedures the type of therapy to be instituted, and the duration of treatment Not only would this benefit the patient and hasten his recovery but it would reduce the cost of medical care in many matances where such procedures are used beyond the possibility of further benefit. The physician should also be aware of the advantages of providing for the retraining of industrially disabled workers. The laws provide for vocational rehabilitation and also for sur gical services and hospital care when needed and these measures should be employed at the earliest possible moment

Quality of Medical Care.-We believe it is essential to the fulfillment of the functions devolving upon the medical societies under the Workmen's Compensation Law that they pay more attention to the improvement of medical care provided the in jured worker Through scientific meetings and grad uate courses many opportunities are afforded phy sicians not only to keep abreast of progress in the medical sciences but to improve their diagnostic and technical skills County societies can also provide interesting programs in industrial medicine and in other matters relating to the administration of the Workmen's Compensation Law, ande from the purely economic matters which also require considera-tion by the organised profession. The Workmen s Compensation Committees through their relation ships with carriers and employers, and oven with organized labor groups, can give consideration to the purely professional aspects of workmen a compensa-tion practice. While this is related to the question of the qualification of the physician or specialist for his task (which societies have ample power and authority to control) situations arise where the competence or ethics of a particular physician is ques-tioned, and here it is the duty of the Workmen s Compensation Committee to give full consideration to any complaint by any interested party in accord ance with the provisions of the Workmen's Compensation Law (13-d) In other words the time has come to pay more attention to the quality of medical care rendered by physicians on the panel

Medical Bureaus.—During the past few years the Workmen's Compensation Committees of the medical societies have given greater attention to the licensing of employers' and physicians' medical Under the provisions of the Workmen's Compensation Law, no such license may be issued without the approval of the medical society, or the Medical Practice Committee in New York City, and no renewal should be permitted without the sanction of the Workmen's Compensation Com-Medical bureaus should be rigidly inspected to determine whether they are adequately equipped to meet the needs of the particular hazard encountered and whether the Bureau has adequate space, is sanitary and clean, and properly staffed by physicians during the working hours of the plant. While While it may not be necessary in a given bureau for the physician to be present constantly, he should spend a sufficient amount of time each working day to treat patients properly and to see all minor injuries sustained in his absence He should be available at all times for emergencies Care must be taken that the nurse does not exceed her authority and act as a physician instead of as the agent of the physician in his absence with limited authority and scope Substitutes should be available during illness or vaca-It should be the function of the Society to see that patients are not denied free choice of physician by the medical bureau and that waivers are signed by those who prefer to be treated at the Bureau rather than to exercise their right to free choice either originally or in the course of treatment The purpose of the employers' medical bureau is to make medical care promptly available to the injured worker, with his consent and within the spirit of the provisions of the Workmen's Compensation Law It is not a means of enabling the employer to direct the choice of a physician and thus deny free choice

M-17 Thoracic Surgery —The creation by the House of Delegates of the American Medical Association of a new section in chest diseases brings up again the necessity of recognizing the subspecialty of thoracic surgery We have repeatedly recommended that physicians who can qualify as specialists in thoracic surgery be given a specific rating of M-17 as was the case under previous administra-

tions of the Department of Labor

Fee Schedule—The Workmen's Compensation Committee in its Annual Report to the Council and to the House of Delegates in 1942, pointed out the need for an increase of fees to cover the increasing costs of conducting medical practice and the then already mounting cost of living An inquiry was directed by our Bureau to the chairmen of all Work-men's Compensation Boards and Committees throughout the State on December 6, 1941, requesting detailed information on this subject. These inquiries were collated and definitely indicated that the fee schedule was much too low. The elimination of the 5 per cent discount allowed for the payment of medical bills over \$15 within thirty days was de-This information was sent to the manded by all Hon Frieda S Miller, Industrial Commissioner, on November 19, 1942 Miss Miller was not re-appointed by Governor Dewey, who took office on January 1, 1943, so the matter was held in abeyance pending the appointment of a new industrial commissioner

On May 14, 1943, a communication was sent to the Acting Industrial Commissioner, Mr Michael J Murphy, requesting a revision of the fee schedule and giving our reasons for same Shortly thereafter, the Moreland Act investigation was begun, putting a stop to all activities in this direction for more than a year

In the report of the Bureau to the Council and to

the House of Delegates in 1943, and after further systematic inquiries throughout the State as to the cost of the various items entering into medical practice, the Workmen's Compensation Committee stated that it was prepared at an opportune time to press for an increase in the fee schedule and for the removal of the 5 per cent discount. As a result of recommendations made to the House of Delegates, a resolution was passed at the Annual Meeting in May of 1944, calling on the industrial commissioner to grant an increase in fees and also to remove the discount of 5 per cent Similar resolutions were passed in 1945 and in 1946 On May 7, 1946, and on June 10, 1946, the chairman of the Workmen's Compensation Board was notified of the action taken by the House of Delegates At that time the chairman of the Workmen's Compensation Board was also asked to give consideration to temporary revision of the fee schedule and to remove the assistant's fee from the fees allowed for hernia operations July 18, 1946, the chairman stated that she was considering a revision of the fee schedule and requested the president of the State Medical Society to submit a report on the amount of remuneration deemed by the Society to be fair and adequate for medical care On September 12, 1946, a meeting was held with the chairman of the Workmen's Compensation Board and a fee schedule, prepared by our Workmen's Compensation Bureau and endorsed by the president of the State Medical Society and by the Council, was submitted to the chairman At that Council, was submitted to the chairman time the chairman requested your director to obtain statements from physicians throughout the State concerning the relationship of the proposed fees to fees paid in private practice by persons of a like standard of living to those treated under the Workmen's Compensation Law This material was subsequently transmitted to Miss Donlon

In November, 1946, we were informed that the chairman of the Workmen's Compensation Board intended to appoint a committee under the chairmanship of Dr Nathan B Van Etten to consider revision of the fee schedule This Committee* was subsequently appointed On March 27, 1947, the director of the Bureau appeared before the Committee of the Committee mittee and presented arguments in favor of the adoption of the increased fee schedule as presented to the chairman of the Workmen's Compensation Board

by the president of the Medical Society of the State of New York, Dr William Hale The Advisory Committee subsequently held a number of meetings and on May 2, 1947, the chairman of the Workmen's Compensation Board announced a partial revision of the fee schedule, effective June 1, 1947 (revision attached)

MEDICAL FEE SCHEDULE

MEDICAL FEE SCHIDULE

By virtue of the authority vested in me by Sections 13(a) and 141 of the Workmen's Compensation Law I Mary Donlon chairman of the Workmen's Compensation Board hereby promulgate the following rule establishing a revision in the schedule of fees for medical treatment and care under the Workmen's Compensation Law for the State of New York.

The medical fee schedule heretofore established by the Industrial Commissioner of the State of New York, as last amended by rule promulgated March 8 1941, and adopted by the chairman on April 2 1945 is further amended by these rules

rules

Items lines numbered 49 to 55 inclusive of the medical 1 fee schedule are amended effective as herein provided as follows on next page

^{*} Advisory Committee Dr Nathan B Van Etten Chairman Dr W P Anderton Mr Henry D Sayer Mr Martin Hilfinger and, Mr Edward W Edwards

Line Number	Item	Гее
49	First whit home call, including examination	\$5 00
50	First visit office call including	\$3 50
51	Office call	\$2 50
51 52	Home call other than night	\$1 00
53	Home call night emergency (call received by doctor between 10 P.M. and 7 A.M.)	\$6.00
54	Hospital call, other than night	
	emergency	\$2 50
55	Consultation of attending phy- gician with specialist attending physicians fee same fee as re- gular call or visit	

There is established the following new item line numbered 51(a);

Line Number	1tem	Foe
54(a)	Hospital call, night emergency (call received by doctor between 10 r m, and 7 a.m.)	\$2 00

3 Item line numbered 1, providing for a discount of 5 per cent on all medical bills in amounts of \$1 or more if paid within thirty days is hereby recinded effective as herein provided

4. Rules I and 2 above shall become effective June 1 1947 and shall be applicable to medical care and treatment rendered under the Workmen a Compensation Law in new cases arising or old cases reopseed on and after that date with respect to medical ears and treatment rendered on and after June I 1947 in pending cases that arose prior to June I 1947 the provisions of the present fee schedule shall continue to be effective.

5 Rule 3 above shall become effective June I 1947 with respect to all bills rendered on and after that date

On November 23, 1947 we were informed that the chairman of the Workmen's Compensation Board would hold an open hearing on the fee schedule compiled by the Advisory Committee on December 15 1047 at the State Office Building 80 Centre Street New York City A notice of this hearing was sent at once by this Bureau to all county medical societies and to a number of special groups throughout the State, who were urged to come to the hearing and present their views on all the items in the proposed fee schedule and on the few items which had already been promulgated At this hearing an opportunity was given to a number of physicians representing the county medical societies and also to your chairman and director to present their views

A copy of the proposed fee schedule which had been received in this office just before Thanksgiving was placed on file in the office of the chairman of the Workmon's Compensation Board for review by all interested parties Our Bureau mimcographed same and sent it out to all county medical societies throughout the State in the brief space of time (less than three weeks) prior to the hearing. At the hearing it developed that sufficient time had not been given prior to the hearing for the proposed fee sched ule to receive full study and consideration by physi cians throughout the State and the chairman of the Workmen's Compensation Board after consultation with the members of the Advisory Committee who were present at the hearing, graciously allowed an additional month and a half (to February 1 1948) for your Bureau and interested physicians to present additional suggestions for changes in the schedule proposed by the Advisory Committee Your director was invited to confer with Dr Van Etten and to submit to him (both before and after the open hear ing) suggestions for revision of the Advisory Committee's schedule. The entire proposed fee schedule was reviewed and numerous additions and changes were suggested which were in line with recommon-

dations received from county societies and special groups in answer to our inquiries.* A copy of the proposed fee schedule will be presented to the Refer ence Committee

The fees already promulgated on June 1 1917, are not considered adequate by many physicians and county societies, and resolutions concerning same have been received from Albany and other counties. It seems to be the opinion of many physicians throughout the State, particularly in the larger counties that the increase allowed for office, home and hospital visits over the fees promulgated more than ten years ago are not in proportion to the increase in the expense of conducting medical practice and the drop in value of the dollar in this inflationary period. This matter has again been drawn to the attention of the Advisory Committee which at this writing has the matter under consideration

Minimum Medical Fee Schedule -At the open hearing on December 15 1047 and on other occasions we have urged that the fee schedule be entitled 'Minimum' Medical Fee Schedule. The original fee schedule promulgated in 1936 was entitled Minimum Medical Fee Schedule compelling reasons why the present fee schedule should also be called a Minimum Medical Fee Sched ule, otherwise it might be concluded by the profession and by employers and carriers that the fees in the schedule are the maximum that a physician may charge for his services. The Council of the State Medical Society at its regular meeting on Decomber 11 1947 voted to go on record as insisting that the Fee Schedule be called a Minimum Medical Fee Schedule.

An analysis of the pertinent sections of the Work men s Compensation Law was made by this Bureau in February of 1947 following the passage of resolutions by a number of county medical societies to the effect that unless the minimal fee schedule was promptly increased they would charge fees in accordance with the prevailing rates in private practice

As a result of these resolutions the chairman of the Workmen a Compensation Board sent a communica tion to the insurance carmers not to pay fees in excess of the minimum except on a showing of extraordinary services in a particular case. It was the opinion of the chairman of the Board that the Albany County Medical Society had established their own fee sched ule and such fees could not be paid without violat-It is conceded that the Albany County ing the law Medical Society had no authority to establish fees this being the prerogative of the chairman of the Workmen's Compensation Board acting on the recommendations of the president of the State Medical Society after taking into consideration the views of other interested parties. But the Albany County Medical Society did not establish a fee schedule. They simply resolved that they would charge fees in excess of the minimum for services rendered after a certain date unless the chairman of the Workmen s Compensation Board increased the minimum fees and if their medical bills were not paid, they would then submit them to arbitration

This raised the question as to whether the fee sched ule is a fixed minimum one, whether physicians may render bills in excess of the minimum and whether employers and insurance carriers may pay fees greater than those established in the fee schedule without violating any provision of the Workmen a Compensation Law

^{*} New Lork State J Med. 48; 315 (Feb. 1) 1018,

Section 13(a), entitled Treatment and Care of Injured Employees, states

The chairman shall prepare and establish a schedule for the state, or schedules limited to defined localities, of minimum charges and fees for such medical treatment and care, to be determined in accordance with and to be subject to change pursuant to rules promulgated by the chairman Before preparing such schedule for the State or schedules for limited localities the chairman shall request the president of the medical society of the State of New York to submit to him a report on the amount of remuneration deemed by such society to be fair and adequate for the types of medical care to be rendered under this chapter, but consideration shall be given to the view of other inter-The amounts payable by the emested parties ployer for such treatment and service shall in no case be less than the fees and charges established by Nothing in this schedule, however, such schedule shall prevent voluntary payment of amounts higher than the fees and charges fixed therein, but no physician rendering medical treatment or care may receive payment in any higher amount unless such increased amount has been authorized by the employer, or by decision as provided in Section 13-g therein

Section 13-g provides that an employer shall pay a bill as rendered unless within thirty days such employer shall have notified the chairman and such physician or hospital in writing that such employer demands an impartial examination of the fairness of the amount claimed by such physician or hospital In the event that no such timely objection is made in a compensable case, such examination shall be deemed to be waived, and the amount claimed by such physician or hospital shall be deemed to be the fair value of the services rendered by him or it Herein no mention is made that such fee must be in accordance with the minimum fee schedule section further provides that if the parties fail to agree as to the value of the medical care (where objection has been made to the bill as above), the value of the services shall be determined by arbitration or by decision of the Medical Practice Committee in the four New York counties having a population of one million or more

Attention is drawn particularly to that portion of Section 13(a) which states

Nothing in this schedule, however, shall prevent voluntary payment of amounts higher than the fees and charges fixed therein, but no physician rendering medical treatment or care may receive payment in any higher amount unless such increased amount has been authorized by the employer, or by decision as provided in Section 18-g herein

Note well the alternative here

The law definitely provides, however, that a physician may not charge less than the minimal fee Were he to do so, he would be guilty of violating Section 13-d, 2(d) of the Workmen's Compensation Law which provides that the

chairman shall remove from the list of physicians authorized to render medical care under this chapter the name of any physician who, he shall find after reasonable investigation, is disqualified because such physician has rendered medical services under this chapter for a fee less than that fixed by the chairman as the minimum rate in his locality

In this section there is no provision for penalties where a physician requests or accepts a fee in excess of the minimum

Section 13(a) expressly provides that the employer or his insurance carrier may voluntarily pay fees in excess of the minimum. There is the requirement that the doctor request authorization for fees in excess of the minimum. In view of the exigencies of medical practice, it is often impossible for a physician to evaluate his services in advance. Therefore, there is the alternative provision that the employer may, if the doctor renders a bill in excess of the minimum, have the value of his services determined by arbitration.

Section 13-g, moreover, does not provide that arbitration may not be had by the doctor if he submits a bill in excess of the minimum. No mention of a minimum fee is there made. It distinctly states that the bill he submits shall be deemed to be the fair and reasonable value of the services rendered if the employer or carrier does not object to same within thirty days Section 13(a) distinctly provides relief in the form of arbitration in the event that a physician asking a higher fee than the minimum is Even if the employer voluntarily refused to authorize a fee in excess of the minimum after request, the value of such bill, if objected to, shall be determined, as the law provides, (13-g) by arbitra-No authority is given an employer to refuse to pay a fee in excess of the minimum even if the physician refuses to accept the minimum cision as to the value of such disputed services rests To hold otherwise with an arbitration committee would be to violate the spirit of the Workmen's Compensation Law, which provides for amicable settlement of disputed bills

In view of the above, it would appear that it was an error to instruct insurance carriers that they may not pay fees in excess of the minimum except on a showing of "extraordinary medical services in a particular case". To do so was to fix fees at the minimal level which is contrary to the letter and the spirit of the Workmen's Compensation Law 13(a) and entirely ignores the alternative which provides for arbitration under Section 13-g. The employers' remedy lies in arbitration if a bill in excess of the minimum is rendered without prior authorization.

The fees paid physicians in compensation practice are basically determined by the prevailing fees paid for medical services in private practice by persons of a like standard of living The minimum fee schodule paid in compensation cases, established in 1936, is conceded to be well below these prevailing rates today, and the physician may, therefore, feel justified in requesting a fee in excess of the minimum as then established, it may be that the employer or his carrier may be satisfied that such demand is justified and may pay the doctor He may do so in our opinion without violating the Workmen's Compen-Furthermore, the social status of the sation Law particular patient, or his salary as an insured executive, may justify a fee in excess of the minimum, especially if said employe demands, and either pays for or obtains from the employer or carrier, facilities and services in the hospital which are well above those provided the average working man tent and severity of an injury, not always determinable before treatment, may justify a higher fee, therefore, there are more reasons for requesting or demanding a fee in excess of the minimum than the performance of "extraordinary service in a given case" The alternative provision for arbitration in section 13(a) was no doubt included and is necessary to provide for the fair determination of the services rendered under these variable circumstances.

There is one definite compelling provision in the

law relative to fees and that is that an authorized physician may not charge less than the minimum under penalties of the provisions in Section 13-d, 2(d) (The employer may not pay less than the minimum.) Here the authority of the chairman of the Workmen's Compensation Board is unquestioned. This provision she must enforce and may request insurance carriers to obey We find no provision in the Workmen's Compensation Law which prevents or precludes payment by an employer or carrier of a fee in excess of the minimum, and an employer in our opinion violates no statute if he pays such excess fee

Workmen's Compensation Qualifications.—On numerous occasions we have drawn attention to the standards of qualification set up by the Workmen's Compensation Committee of the Btate Medical Society for practitioners and specialists. These are used by the local county medical societies in recommending physicians for compensation ratings. We have requested that the compensation committees apply these standards meticulously with due regard to the average level of practice existent in any given county. The standards are necessarily higher in a metropolitan county or large city with medical schools and numerous hospitals and clinics than in a rural county. We have urged that specialty ratings be given only to thoroughly qualified physicians who conform in all respects to the standards.

At the outset, many county society committees gave physicians multiple ratings—either \(^\circ\) or S—not consistent with their actual qualifications under the impression that such designations were necessary to indicate the range of a physician spractice. During the past seven or eight years most of the county medical societies have simplified these ratings and have granted to such physicians in general practice an \(^\circ\) rating and other symbols only where the physicians is basic training and experience warranted it. Specialists too, were occasionally given multiple ratings in unrelated specialises, and some of these have not yet been simplified and corrected.

A physician who is a general practitioner is en-titled to an \ rating which clothes him with all the authority necessary to perform the acts of a general practitioner in the community in which he practices. Should be have obtained additional training and experience, basic and institutional over a period of years in one or other of the specialties, even though not confining his practice exclusively to the specialty he may with the approval of the Workmen's Compensation Committee and with the standards as a basis for their action, be given an X rating followed by a symbol of the specialty or field in which he has proved his special qualifications (over and above those of the average general practitioner in his com munity) The specialty rating, indicating the highcet qualifications and conferring special standing on the practitioner in his field of practice, both in relation to his fellow practitioner and in the courts, should be conferred only on such physicians as fully meet the standards set up for the particular area in which they practice. The amount of divergence from the specialty permitted should also be determined by the nature of practice in the particular community or county Multiple specialty ratings except in closely related specialties should not be granted. Custom and local mage will determine which closely related specialty ratings may be conferred on an applicant.

Where a county medical society is in doubt as to a physician a technical ability it may request him to carry out one or more major procedures before a qualified group of experts before passing on his application. As pointed out repeatedly, ratings in reentgenology should not be granted physicians or specialists (other than x ray specialists) unless they have had basic training in general reentgenology. Physicians applying for x ray specialty ratings who intend to limit their practice to radiology should full questionable cases should be certified for examination by the examining committees in radiology set up by the Workmen's Compensation Bureau, avail able to overy local county modical society on request of the Workmen's Compensation Committee

Specialists other than x ray specialists are prosupported youlified to interpret x ray films in their specialty or to render x ray treatment and require no additional qualifications. When patients are referred to them solely for x-ray examination in their own field, they should be paid full specialists' fees.

It is again urged that those county societies, which have not as yet simplified their ratings and where physicians still possess multiple ratings, proceed to review the ratings granted physicians within their jurusdiction. Before so doing every physician whose rating is to be considered for simplification or change should be given an opportunity to appear before the Workmen's Compensation Committee after being given due notice of the impending revision. On the recommendation of the Workmen's Compensation Committee, the chairman of the Workmen's Compensation Committee, the chairman of the Workmen's Compensation Committee and make the change or deny it. The physician, if dissatisfied, has the right of appeal to the Medical Appeals Unit of the Industrial Council

The State of New York is the first state in the union to attempt limitation of medical practice on the basis of proved qualifications to protect the public (in compensation practice) Ultimately similar limitations may be enacted in the Medical Education Laws It is also significant that the legislature conferred upon the medical societies the initial responsibility of setting up boards or committees for determining the qualifications of licensed practitioners Since 1935 these functions have devolved upon the county medical societies, and in 1944 the law was amended to put the function in counties of over one million population in the hands of the Medical Practice Committee of three appointed physicians

Nearly all physicians and specialists in the State have become authorised under the Workmens Compensation Law and most specialists have obtained the special symbols pertaining to the specialists. The ratings have been accepted by various organizations, such as the Veterans Bureau as evidence of special qualifications. We maintain that the medical societies are best qualified to judge the competence and ratings of physicians and that these functions assigned to the organized profession by the State are carried out faithfully competently and without cost to the people. We urge the county societies to give even greater care to these functions so that the public may have full confidence that a physician is thoroughly competent once he has been adjudged so by the societies.

Radiology Examinations.—At the requests of the county medical societies and of the Medical Practice Committee, your Bureau arranged four examinations in diagnostic reentgenology and/or radiation therapy for physicians whose qualifications were in doubt. Since the last annual report examinations

were held in Albany and New York City for seven-

teen applicants

No applicant for rating in radiology is endorsed unless he fully meets the standards of education, training, and experience set up by the county and state medical societies. The diploma of the American Board of Radiology is usually accepted as evidence of qualification, although a number of physicians who first tried our examination and failed were subsequently passed by the American Board. The Medical Practice Committee in two instances failed to follow the recommendations of our examining committee and the endorsement of the county society after the applicants successfully passed an exhaustive examination, on the ground that the applicants had not been in x-ray practice long enough. They were given an XD rating

Physicians who successfully passed the examination are entitled to receive a specialty rating if they restrict their practice to radiology. The years of private practice rule in clinical subjects should not necessarily apply to radiology or to the laboratory

nelds

Arbitration —According to the provisions of Section 13-g, 2, if a doctor and the insurance carrier fail to agree as to the value of medical aid in a compensation case to a claimant residing in a county-having a population of one million or more (that means in the counties of New York, Kings, Queens, and Bronx), the law provides that the value of medical care shall be decided by the Medical Practice Committee, and in other cases it shall be decided by an arbitration committee, consisting of New York appointed by the employer or insurance carrier, the medical society, and the chairman of the Workmen's Compensation Board

It should be noted that on the one hand the Medical Practice Committee decides the value, while on the other hand five physicians arbitrate the issue as an arbitration committee and establish the value

of medical care

Under the rules and regulations governing the arbitration of medical bills, the employer or insurance carrier and the doctor both sign the regular submission forms accepting the arbitrators and agreeing to abide by the decision of the arbitration committee

In the four Greater New York counties the physicians usually appear before one member of the Medical Practice Committee Aside from the fact that there is quite a difference between a decision by one or two members of the Medical Practice Committee and an arbitration by a committee of five physicians, there is the likelihood in a group of five that the particular facts incidental to the dispute would be familiar to one or more members of the group, while it is less apt to be so where the issue is heard by one doctor Furthermore, a specialist, rendering a bill for special services of an unusual nature, could request that at least one member of the arbitration committee of five be a specialist in, and familiar with, the type of practice, the value On the other hand, of which is being disputed where all the members of the Medical Practice Committee are, let us say, surgeons, the chances of their being familiar with the value of all types of special service are small.

In deciding the value of medical services, it is important that the person acting as an arbitrator meet the parties to the dispute face to face and be able to interrogate them. Under the ruling of the attorney general handed down on May 18, 1945, at the re-

quest of the chairman of the Workmen's Compensation Board, one of the members of the Medical Practice Committee may take testimony and hear the parties in relation to the disputed bill and report back to the full committee, two of whom render a decision

We deem it unsatisfactory and unrealistic for one member of the Medical Practice Committee to hear the issue, make a finding, and expect the other two members of the committee who have not seen the parties or heard the argument, to disagree with the finding and decision of the one member

Taking into consideration the provisions set up by the Legislature as recently as last year for the arbitration of hospital bills by four persons, at least two of whom must be physicians, one wonders whether the hearing of evidence by one physician can result in a fair, reasonable, and equitable de-

cision of medical bills

In view of the multiplicity of medical problems that arise concerning medical bills in the various fields of medical practice, as well as the technical questions involved as to type and value of treatment, can a committee of even three physicians, all in the same medical specialty—to say nothing of one physician as now permitted—do justice to all parties concerned? This raises the question as to whether the new procedure will result in carrying out the "reasonable provisions of the law"

The medical profession has a vital interest in the settlement of bills in an equitable and fair manner Arbitrary awards and hasty decisions based upon inadequate consideration of all the evidence without a full hearing by a full board may well alienate many of the best qualified practitioners and thus limit

greatly the choice of an injured worker

Although the House of Delegates has resolved that a strong effort be made toward the abolition of the Medical Practice Committee and the restoration of functions to the four New York counties where the Medical Practice Committee has jurisdiction, should not steps be taken, pending the success of legislative attempts to abolish the Medical Practice Committee, to modify the system of one-man settlement of disputed bills so that the practice is more in conformity with the arbitration procedure in effect throughout the rest of the State? We believe that we should and will exert our influence to achieve this to the best of our ability

In the year 1947, arbitrations were held in West-chester twice, in Albany for nine adjoining counties, in Buffalo for one adjoining county, in Rochester for three adjoining counties, in Utica for three adjoining counties, and in Newburgh for three adjoining counties. We will shortly make a tour of the State again,

including the southern and western tier

During 1947, arbitration committees of the county medical societies scheduled 214 hearings and disposed of 107 disputed medical bills aggregating \$10,293 25, on which they awarded fees of \$5,170 75 Assessments on those county society arbitrations totalled \$602 65

During 1947, the Medical Practice Committee received 10,263 carrier objections to medical bills for services rendered to claimants resident in the counties of Bronx, Kings, New York, and Queens There were disposed of, in 1947, objections to 7,717 bills, an additional 499 bills were ready for hearing at the end of the year, and a number were awaiting determination of controverted workmen's compensation claims or objections to payment because of the physician's failure to file required medical reports Hearings scheduled in 1947 before the Medical

Practice Committee related to bills aggregating \$468,044 on which the Committee awarded \$70 692.85 some objections being withdrawn before hearing Assessments on Medical Practice Com-

mittee awards aggregated \$9 944 56

The chairman received requests from 121 claimants to assist in recovering from physicians fees paid for medical treatment in workmen a compensation cases for which the physicians should bill carriers, and obtained during 1947 reimbursement by physicians to 98 claimants aggregating 37,437. On December 31 1947 there remained for further in vestigation and disposition the reimbursement re-

quests of 23 claimants

Group Practice and the Workmen's Compensation Law — The passage of the Griffith Bill (Senate Int 740) by the Legislature in 1947 legalized partnerships in medical practice and permitted the partners to pool fees for medical services and to share, apportion or divide these fees among the partners in the group However the bill specifically provides that "no such sharing division, or apport tonment shall be permitted with respect to fees recuved for rendering medical care and treatment under the Workmen's Compensation Law

Thus no medical group in this state may apply the contractual relationship permissible in ordinary practice to money received by a group for treating a compensation patient. Each physician must bill individually and retain all fees for medical care to in

jured workers.*

Hospitals and Medical Practice —The attempts to differentiate between medical practice under the Education Law and under the Workmen's Compensation Law as pointed out above, raise barriers to practical solutions directed toward implementing medical practice especially in our hospitals. For example many hospitals find it practical where full time services are essential to employ certam physicians on a contractual relationship in x-ray, pathology and even in anesthesiology and physical medicine.

Most physicians in these specialties, however desire to bring about and maintain the same relationships in hospital practice as do other physicians such as medical men, surgeons, etc. The specialty groups are working for individualistic relationships and the same recognition of their specialties as are accorded other physicians on the medical staffs. It would take us too far afield to try to present all the arguments pro and con Custom has decreded estain practices, especially in the larger institutions, in respect to the full or part time employment of these specialists on a salary basis often unrelated to the value of the services rendered or to the facilities placed at the disposal of these physicians by the institutions. Certainly inequities have arisen which are justly denounced by in dividual specialists or by their representative

The hospitals have not infrequently operated these departments not solely for the welfare of the patients or for the advancement of medical science but frequently for general rovenue making a profit out of the doctors services over and above all reasonable costs including overhead depreciation and obsolecence Of course these practices could not be maintained without the participation of physiciana, some of whom in the past eagerly solicited such employment. Certain nospitals assert that these ancillary services cepecially x-ray and anesthesiology cannot be sup-

plied at a reasonable cost to the patient without some sort of contractual relationship involving full or part time service, and in some quarters it is asserted that the public has come to look upon them as hospital rather than medical services.

Our position in this matter has often been recorded not only in our reports, but in our discussions corted not only in our reports, but in our declarations and agreements with groups such as the New York State Hospital Association These specialties (roent-genelogy, pathology, anesthesiology and physical medicine) are and should be recognized as the practice of medicine The Medical Practice Act and the Workman a Compensation Law should be so revised as to leave no doubt about this. Once being so recognized, these specialties should be accorded the same privileges and subjected to the same limitations as are all other medical and surgical services. very preservation to say nothing of the further development of these specialties, depends upon the affirmation of the above principle. Exploitation by hospitals of these physicians through inequitable contracts will no longer attract the type of men equipped to carry the torch for the further scientific development of medicine. Indeed should the situa tion not be remedied by wise legislation soon there may not be sufficient well trained men available to staff even existing institutions.

The Workmen's Compensation Law and the Education Law should be so explicit as not to permit the practice of medicine by other than regularly licensed physicians. Hospitals as corporations should not be permitted to practice medicine but only to provide the means for physicians to practice

medicine

The Workmon's Compensation Law in one section specifically states that only a duly authorized physician shall be paid for medical and surgical services but despite the spirit and intent of the law thus emindated other provisions permit the practice of roontgenology by corporations firms, and unlicensed persons through the employment of physicians. The Workmen's Compensation Law specifically states that hospitals shall not be entitled to the fees paid to physicians but nevertheless permits hospitals to obtain a license to conduct an viray laboratory and to employ physicians and collect for their services. This amondment seems definitely to be in conflict with Section 13-d 2(g) Hospitals may not practice medicane and should not be permitted to do so by indirection.

These ambiguities in the law require change in accordance with the fundamental principle laid down by the legislators in the amendment to Section 13 of the Workmen s Compensation Law and in the spirit of that law as so amended if we are to avoid a deterioration in the quality of medical care

Legislation.—From year to year since the creation of the Workmen a Compensation Bureau, we have suggested legislation to improve the administration of the Workmen a Compensation Law Sometimes this took the stape of new statutes or amendments

to existing provisions.

We have constantly opposed measures which in our judgment tended to weaken the administration of the Workmen a Compensation Law or to lower the quality of medical care. Although we opposed measures to narrow the sphere of influence and re sponsibility of the medical societies in the administration of the Workmen a Compensation Law, we have not always been successful and in no small measure our failure may be ascribed to a lack of concerted and vigorous action by the local county societies and lack of interest on the part of indi-

^{*} N w York State J Med 48: 316 (Feb 1) 1918.

vidual physicians, who, more often than not, expect our legislative committee and the Workmen's Compensation Bureau to do what can only be done by individual and group action in every city, town, and village through the people's representatives in the Senate and Assembly

It is perhaps wearying for us to point out year after year that under the provisions of the Workmen's Compensation Law, the medical societies have, for the first time since the licensing of physicians was carried out by the State Medical Society many years ago, regained a large measure of responsibility in the control of medical practice in this State.

It is only natural with the granting of free choice of physician and the benefits incidental thereto that the Legislature should have looked to the organized medical profession for help, guidance, and some degree of control in carrying out the provisions of the law relating to medical practice under the Workmen's Compensation Law have made suggestions and again this year draw attention to the need for our exercising this control through the county societies in so efficient a manner that the confidence placed in us is justified must deliver high quality medical care at a reasonable and fair cost, comparable with costs in private practice to persons of a like standard of living these days of mounting governmental budgets, it might be well to point out that the functioning of the medical societies in the Workmen's Compensa-tion picture is without cost to the State The return of medical functions to the medical societies in the counties having a population of over one million, as we plead for elsewhere, would not only make for better relations and administration but would lower materially the costs of the medical administration of the Workmen's Compensation Law

We agree with the sentiments expressed by Governor Dewey in his speech on February 20, 1948, before the New York Heart Association Governor Dewey states that after eighteen years in government service he was certain that government could never do any job as well as private enterprise

Your Committee has recommended and the Council has approved and referred to the legislative committee for action at the 1948 session of the Legislature, the following *

1 To amend Section 13-g (2) of the Workmen's Compensation Law, to make the place of arbitration of disputed medical bills, the county in which the services were rendered rather than the county in which the employe resides (Senate Int 2078,

Halpern)

2 To amend Section 13-b (2) to provide that a physician's rating under the Workmen's Compensation Law shall be altered (depriving him of a rating already given) only after a hearing is given him by the county medical society or Medical Practice Committee after full notice, and further, that if such change is made and the physician appeals to the Medical Appeals Unit of the Industrial Council, that the findings and conclusions of the Medical Appeals Unit shall be conclusive and binding on the charman of the Workmen's Compensation Board and not merely advisory to her as at present (Senate Int 1708—Condon, 1947)

3 In accordance with the mandate of the House of Delegates, legislation has again been introduced to abolish the Medical Practice Committee in counties of one million and over and restore the

functions to these county medical societies as now applies in all other counties in the State

4 To amend the Workmen's Compensation Law, Section 13-a (5) to raise the level of the amount of services (consultation, surgical operations, or physical medicine) from \$25 to \$35 and from \$10 to \$20 (laboratory and x-ray examinations) requiring authorization, except in emergency

5 To confer with the chairman of the Work-

men's Compensation Board to bring about an amendment to Section 13-1 which denies employers and carriers the right to provide medical care but gives them the right to make medical inspections, but in such manner that medical examinations shall be made in accordance with the provisions of Section 13-a (4) viz, in the presence of the employe's physician if the employe or his physician deems it

necessary or advisable.

6 Senate Int 618 (Condon) amended the Workmen's Compensation Law to permit the designation of especially qualified physicians in the various specialties to examine and report upon claimants referred to them by the Workmen's Compensation Board or by the referee on the recommendation of the Compensation Medical Director Such specialists are now designated by the chairman of the Workmen's Compensation Board in her discretion It was voted at the meeting of the Council on December 11, 1947, that an amendment be sponsored that such appointments be made from lists of physicians recommended or approved by the state or county medical societies

or county medical societies
7 To oppose any legislation such as the Bewley
Bill (Senate Int 722) to permit the establishment of
medical bureaus by groups of employers in counties
of 100,000 or less as inimical to the free choice prin-

ciple (and for other reasons) *

8 To further legislation to define the practice of roentgenology as the practice of medicine as exemplified by the Clancy Bill (1947), but to avoid the practice of medicine by hospitals or corporations by indirection

9 To give consideration to legislation eventually for the inclusion of all the four specialties, roentgenology, physical medicine, anesthesia, and pathology,

as the practice of medicine

State Employed Physicians *-In February of 1946, we received complaints from various workmen's compensation committees upstate that the Workmen's Compensation Board had declined to authorize physicians employed by State institutions to practice under the Workmen's Compensation Law, despite the recommendations of the county society committees that they were professionally qualified and their services needed in the community. The chief objection of the charman of the munity The chief objection of the chairman of the Workmen's Compensation Board was that their full-time employment by the State would make them unavailable at all times to testify at referee and board Appeals by the physicians and by the societies involved were in vain. It was pointed out that services of the physicians were needed, especially in the rural areas where specialists were not We have conferred with Comalways available missioner MacCurdy of the Department of Mental Hygiene, after an opinion by the attorney general on the matter, who has agreed to send to the chairman of the Workmen's Compensation Board a letter recommending the authorization of these physicians It is hoped this will result in the prompt authorization of the physicians in question

^{*} New York State J Med 48 317 (Feb 1) 1948

^{*} New York State J Med 48 316 (Feb 1) 1948

Public Relations.—One of the important reasons for maintaining the Workmen's Compensation Bureau aside from assisting the county medical societies and the profession generally in their work men a compensation problems is to better public relations in the field of workmen a compensation The state and county medical societies have assumed important responsibilities under the Workmen a Compensation Law These are chiefly in relation to medical care As has been pointed out on many occasions the purpose of workmen a compensation is to assure the injured worker prompt and high quality medical care in addition to compensation for time lost from work. The Workmen's Compensa tion Bureau aims to facilitate the administration of the law in so far as it affects the medical profession that physicians services are at the disposal of in jured workers on the same basis as in private practice

Year after year there has been a noticeable improvement in relations between the medical profession and the other interested parties in the function ing of the Workmen's Compensation Law. All this redounds to the benefit of the injured worker in that it removes disputes misunderstandings and disagreements over the provisions of the law and rules and regulations pertaining thereto as they affect the

practicing profession

The work of the Bureau has increased each year as evidenced by the greater volume of communications between county societies, physicians and the Bureau. In recent years we have sponsored round table and panel discussions on workmen s compensation matters before numerous county medical so-detice throughout the State, in which discussions representatives of labor insurance carriers, employers and the Workmen's Compensation Board participated. This has afforded an opportunity for receivance of views on all workmen's compensation problems and an opportunity for better under standings between the medical profession and those with whom they come in contact in the treatment of compensation patients and in the adjudication of compensation patients and in the adjudication of compensation claims.

Despite the fact that the vast majority of individual physicians are held in high repute and are greatly respected generally the profession as a whole has not enjoyed a good press or what is commonly known as good public relations. Attempts are being made by national state county and local medical groups to remedy this attuation by the employment of skilled public relation counselors to help medicine state its case properly and to win the approbation and support of the public. Its doubt, medicine is altruistic and public spirited primary aim is to serve the public not only in the treatment of disease but in the protection and preservation of the public health These motiva preservation of the public health tions have not always been understood by the public, and the profession has even been accused of material istic motives and monopolistic tendencies attempts to preserve and improve the quality of medical care by opposing measures designed to weaken education laws have often been misunder stood. Organized medicine has had occasion more often to oppose harmful legislation than to offer constructive measures to improve the lag in the distribution of medical services

In so far as Workmen a Compensation legislation is concerned, it can be truthfully said that the or gamined medical profession has made a constructive contribution to the welfare of the public in affording the injured worker the highest quality of medical

caro. The basic change of the Workmen's Componaction Law in 1935 which resulted from the recommendations made by the medical profession assuring free choice of physician to the employe and placing medical practice in a large measure under the control of organized medicine is but one example of constructive effort.

It has been necessary in the past to oppose numerous measures designed to weaken the structure created in 1935 and constructive legislation designed to improve the administration of the Work men's Compensation Law and facilitate the render ing of medical care has been offered almost every

year

We must continue to better our relations with the Workmen's Compensation Board, which is the central administrative authority under the Work men's Compensation Law in this State. We have enjoyed a full measure of cooperation from the various district administrators of the Workmen's Compensation Board and with other branches of the department.

We have endeavored to create closer relations with the chairman of the Workmen s Compensation Board and her office in an effort to facilitate the administration of the law so far as the medical profession is concerned. We shall persist in these efforts, since there are numerous problems that can only be re-

solved on the highest level

We feel, too that we have something to offer as a result of our experience in directing the Workmen's Compensation affairs of the State Society and the local county medical societies over the last twelve years which should prove of value to the chairman of the Workmen's Compensation Board. A review of our Annual Reports to the House of Delegates will substantiate this statement.

The creation of the Joint Council is an example of our bond of association with insurance carriers and self-insured employers. We have a common interest that is best served by mutual respect and understanding. It has undoubtedly been conducive to botter understanding and good will between the profession and these groups Many of the best qualified physicians who in the past have been alienated by disputes and misunderstandings are today eagerly participating in the treatment of workmen's compensation claimants, because those sources of irritation and ill will have been promptly resolved through our close contact with those who pay the medical bills.

Organised labor has a vital interest in the proper administration of the Workmens Compensation Law and here too there is opportunity for closer cooperation and better understanding between the labor groups and the organised medical profession. Such closer relationships should be fostered

This Council Committee washes to record its appreciation of the high quality of service rendered by Dr David J Kalaski the Director of the Workmens Compensation Bureau. His many years dassociation with the work of this Bureau, his intimate knowledge of the Workmens Compensation Law his loyalty and cooperation and the considered judgment he has brought to the resolving of many of the controversial problems have greatly facilitated the work of the Committee. The efficient manner in which the daily tasks of the Bureau are handled is a tribute to his administrative ability.

The Workmen's Compensation Bureau is extremely fortunate in having had the uninterrupted services of its accretarial staff, Miss Elizabeth H. Wheeler and Miss Alice E. Wheeler since the very

inception of the Committee on Workmen's Compensation of the State Society in 1935. It is a pleasure to commend the Misses Wheeler for their devotion to the interests of the medical profession. The high degree of efficiency with which they have carried out their duties over these nearly thirteen years is reflected in the success of the Bureau in meeting the needs of the Society with dispatch and thoroughness.

PART XI

Publications

During the past year formal meetings of the Publication Committee have been held at approximately monthly intervals, together with interim conferences of the editorial group. Reports of pertinent matters have been made by the chairman at the stated Council meetings of the Society.

It has been the aim of your committee to develop a diversified content for the New York State Journal of Medicine During the past year the editorial section has been expanded, as well as the news columns For the latter, reliance has had to be largely on local newspaper clippings, appeals to county society secretaries have not yielded satisfactory results However, we feel that the members of our Society have been kept apprised of the various medical activities through the State

With the change into new quarters, additional space for the editorial offices was provided, but these are still inadequate for the staff. More shelf space for current magazines is now available, but the contemplated reference library cannot be de-

veloped for lack of quarters

The book review situation was discussed at previous sessions of the House of Delegates and a special committee appointed by the President to study the question, but thus far no solution has been reached The existing arrangement, by which all books submitted to the JOURNAL for review are sent elsewhere, continues to be unsatisfactory far no conclusion which would tend to adjust this long standing difficulty has been reached by the special committee The latest information on the matter is contained in a letter to our legal counsel in which it is stated that the Trustees of the Medical Society of the County of Kings "are of the opinion that, should the State Society desire to have a mutual termination or modification of the original agreement, then it would be incumbent on the State Society to establish a journal, to be known as the Medical Journal of the Medical Society of the County of Kings and Academy of Medicine of Brooklyn, whereby our Society would have all the advantages which it had originally when it published the Brooklyn Medical Journal." As this constitutes an impractical proposal, further comment is withheld for the present by the Publication Committee

Continued difficulties in printing and securing more paper have prevented changes for betterment in the general appearance and size of the Journal long desired by the Committee Also a matter of regret are delays in the distribution of the Journal on stated dates. We are assured by the printers that the improvements under way in their press rooms will soon obviate this. The more prompt publication of editorials and scientific contributions is much to be desired, but an expansion in the number of pages is predicated on an adequate paper supply, and this as yet is unavailable. The increas-

ing price of paper and printing will necessarily reduce the surplus from operations and this will not be so large as in previous years, especially as the revenue from advertising is declining. It is worthy of record, however, that the Journal continues on a self-supporting basis

Careful scrutiny of all advertisements has been maintained The inclusion of formulas and dosages is included in all announcements of medicinal

preparations, and manufacturers usually are found cooperative in this matter. During the past year several advertisements have been dropped from our pages for various reasons and many others changed

in accord with our recommendations

The Directory for the current year is now in production There will be many alterations necessary because of errors and omissions in the previous volume, reflecting changes in addresses, hospital appointments, etc. It is hoped that the new edition will be ready for distribution late in 1948. The Publication Committee, however, is of the opinion that this issue should be designated as of 1949 The costs of production in the future should be given careful consideration by the House of Delegates and the Board of Trustees These have become prohibitive to such an extent that annual publication may be inadvisable. The compilation represents an enormous task and the cost of publication and manufacture will greatly exceed that of previous However, the value of the book is unquestioned as is evidenced by the number of copies ordered and paid for by sources outside of our membership. An issue of 25,000 copies is contemplated for the present volume. The cost of publishing and distributing the 1947 Directory was approximately \$53,000, and the estimate for the current volume is \$63,000. These figures are exclusive of clerical compilation costs and do not take into account income from the sale of volumes and advertising This income, it is hoped, will defray the cost of compilation and will leave a comparatively small margin of surplus to be applied to the actual production costs

It is of interest to record that numerous letters come to the Editor commenting on our editorials, mostly favorable, sometimes critical. We may regard this as evidence that the JOURNAL is widely read. Likewise, its scientific content has resulted in requests for republication in other medical journals, and editorials are likewise frequently quoted elsewhere. All editorial copy is carefully reviewed at formal meetings of the Board before publication

The JOURNAL is the official organ of the State Society and is sent to every member. The Publication Committee, and particularly the editors, would appreciate more frequent comments to assist them in formulating policies. Criticism and suggestions are always welcome and will receive due attention.

A revision of the consulting editorial board has been made in the past year and all branches of medicine are represented. The editors are grateful for the assistance rendered by such consultants in cases where the acceptability of a paper may be questioned.

By resolution of the House of Delegates the Publication Committee is appointed annually and during the past year has consisted of Drs John J Masterson, representing the Board of Trustees, James R Reuling, treasurer, Walter P Anderton, secretary, Mr Dwight Anderson, business manager, Laurance D Redway, assistant literary editor, and George W Kosmak, chairman Your Committee recommends to the House of Delegates the continuation of this body under the directive

previously established by the House of Delegates, as follows "The Publication Committee shall consist of the Scoretary, the Treasurer the Business Manager of the Journal and Directory the Managing and Literary Editors and one member of the Board of Trustees to be appointed by the President after consultation with its Chairman

Attention is called to the publication statistics for the past 24 issues embracing the calendar year 1917

New York State Journal of Medicine

REPORT FOR 1047

REPORT F	or 194	1	
Total number of usues of			
published			24
Total number of pages			2 748
Advertising pages		1 248	
Text pages		1 500	
223 scientific articles	839		
82 editorials	137		
News etc.	191		
Books	39		
Workmen s com-			
penzation	8		
Medical care maur			
ance	12		
Postgraduate edu			
cation	7		
Council minutes	62		
House of Delegates			
minutes	100		
District Branch news	6		
Annual reports, etc.	84		
Index	15		
Total circulation			23 10
Mombers copies		21 788	
Cash subscribers		670	
Advertising copies		478	
Complimentary copies		43	
Exchange copies		126	
Taranago copios		440	

Acknowledgment for efficient and conscientious support is made by the Chairman to the various members of the committee to Mr Dwight Ander son as business manager to Drs Laurance D Red way and Armitage Whitman for the editorial con tributions, to Miss Doris Douglerty and members of her staff, and to Miss Alvina Rich Lewis and her assistants, Mus Elsa Sanford and Miss Anne Gibson for their helpful and efficient cooperation in the production department

Public Relations

The Council Committee on Public Relations (formerly the Council Committee on Medical Publicity) functioned during the past year with the following members

Rochester Floyd 8 Winslow M.D Chairman Dan Mellen, M.D. William C. White M.D. Romo New York City

Releases .- The Committee throughout the year continued releases to the press on the postgraduate sessions held under the auspices of the Council Committee on Medical Education. From time to time releases were issued to the press and cooperation was extended to newspaper and magazine writers on subjects of interest to the general public Not able was the national distribution in This Week for October 20 1047 an article 'Vivisection Lifesaver or Fraud' Much of the material for this article was gleaned from the pamphlet 'Dogs Drugs and Doctors published by the Public Rela tions Bureau.

Four News Letters were issued during the year They went to a selected list of State and county soclety officers and committeemen and members of the Woman's Auxillary

Woman's Auxiliary —Under the presidency of Mrs Harry F Pohlmann the Woman's Auxiliary has rendered excellent service in public relations during the last year Assistance was given by the Public Relations Bureau in production of the Distaff and special bulletins were prepared containing suggestions for assistance by the Auxiliary in legislative This organization is now becoming a formidable adjunct of the State Society in its con tacts with civic groups throughout the State They rendered exceptional services in connection with legislation proposed in 1948 to license chiropractors

Members of the Auxiliary supplied new names of important persons to be added to our steneil mailing A total of 6 000 were hand-picked in various parts of the State bringing our list to approximately

31,000 influential persons

Legislation.-The Public Relations Bureau con tinued this year to work in close cooperation with the Legislative Committee Mr Thomas E. Walsh field representative, spent part of the time during the session of the Legislature in Albany assisting Dr Robert R. Hannon, executive officer Walsh has made a thorough study of the enforcement of the present medical practice act. A preliminary report by the Committee on Public Rela tions to the Council in September embodied a discussion of the weaknesses of the existing laws and suggestions for strongthening procedures. As a rosult of the continued study of the subject by Mr Walsh and Dr Hannon, there was introduced in the 1948 Legislature a bill 'to amend the penal law in relation to treating the human body without hav ing first obtained the proper license. Numerous advantages will accrue in the enforcement of the laws relating to unlicensed practitioners of the heal ing art if this bill should be enacted into law

Several meetings of the Subcommittee on Cult Practice were attended by Dr Winslow Mr Ander son and Mr Walsh Every effort was made to place at the disposal of this committee the results of past experience pertaining to the subject of their

investigations

Assistance was given the Legislative Committee in opposing the Noonan Bill to license chiropractors. Mr Walsh assisted the Woman's Auxiliary in their activities Mr Frederick W Miebach, a new mem ber of the staff employed January 26 visited Buf falo Rochester Syracuse and Utica in this con

Annual Meeting —Advance publicity in the news-papers of the State and "spot" releases issued from day to day were a part of the routine handling of news arising in connection with the Annual Meeting.

An interesting part of the program was the offi cial presentation awards to members of the Society who had practiced medicine for 50 years or more. A total of 71 of these doctors were present at the dinner the remaining certificates were mailed to the recipients In all 432 were so honored Dr Louis II Bauer made the presentations to the recipients present in the form of certificates signed by himself and the secretary Dr W P Anderton On behalf of the recipients Dr Nathan B Van Etten made the response.

The magazine Lafe sent two representatives to cover the dinner The issue of June 23 devoted three pages to 'Old Doctors' telling the story of the telling the story of the event to its 5 000 000 readers.

Publications and Printed Matter —A booklet was prepared and distributed concerning the awards to physicians practicing 50 years or more, entitled, "20,000 Years of Service" It contained pictures of most of the recipients of awards and brief biographical sketches Dr Bauer's speech making the award and Dr Van Etten's response were reprinted with photographs taken at the time of the event These pamphlets were distributed to those receiving awards, and also to the press of the State, libraries, and a selected list of persons who would be interested

"Check and Double Check" has continued in active demand, orders coming to us from various parts of the country — It is planned to issue a new edition

m the fall of 1948

Dr Louis H Bauer's radio talk, "Do We Need Compulsory National Health Insurance?" delivered over Station CBS, May 25, was reprinted and 9,000 copies were mailed to a list of important persons

throughout the State

Public Relations in County Societies —Dr Louis H Bauer, in several talks at District Branch meetings, laid emphasis on the need for more public educational work to be conducted by county societies. It has become increasingly evident that statewide public relations work needs to be amplified by stronger public relations activities in most of our county societies. Where there are paid full-time executives, an excellent job is done, both in maintaining contacts and issuing publicity. Much more news of interest to the local press develops in county societies than in the State Society, yet this fruitful part of public relations work is for the most part neglected.

The activities of the Woman's Auxiliary have improved the situation to some extent. What is now needed is week in and week out contacts with the local press and other agencies on the county level, not only when we seek to have something published in newspapers, but as a continuing arrangement, to be available to help local editors when they seek

information from us

In an effort to promote better understanding of the public, Mr Walsh will continue his efforts to stimulate the organization of Speaker's Bureau functions in county societies. In June, Mr Miebach will conduct a survey of the public relations of one of the county medical societies and prepare a report which may be found useful to other county societies.

PART XII

Miscellaneous

Medical Licensure —The Council Committee on Medical Licensure, consists of the following

Nelson W Strohm, M D , Chairman
Morris Maslon, M D
Ivan N Peterson, M D

Buffalo
Glens Falls
Owego

The Committee wishes to submit the following comments, suggestions, and information for the consideration of the Medical Society of the State of

New York

In reviewing the presentation of licensure statistics of the Council Committee on Medical Education and Hospitals in the Journal of the American Medical Association, we find that during the year 1946, 129 licenses to practice medicine were issued by medical examining boards in the 48 States, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands Of these 16,129 licenses,

6,559 were issued after examination and 9,570 were issued by reciprocity or endorsement of state licenses or the certificate of the National Board of Medical Examiners. This shows a very marked increase in both groups over the previous years.

The greatest number of licenses granted during the calendar year of 1946 by any one state was in California, where 2,045 were issued In New York State over 1,000 were issued There was an increase over the year 1945 in all but three states Arkansas, Indiana, and Tennessee

There was an unprecedented increase in some rural states as well as in certain states having large

urban populations

A more pronounced increase is found in the group

licensed without examination

The group registered after examination was over 1,000 greater than the number issued in the year 1945. This fact would seem to be explained by the migration of veteran medical officers from their original state of practice and medical officers, who were recent graduates, who were licensed prior to entry into active duty and returned to New York State instead of their original state.

Figures indicate that the accelerated program in the medical schools (July 1, 1942, to July 1, 1945) produced 20,662 graduates in this three-year period while in the four years (1942 to 1945, inclusive) 35,821 physicians received licenses. The one extra class graduating under the accelerated program and the increase in the enrollment in all medical schools, intended primarily to supply more physicians to care for the armed forces, is apparently providing a great physician-civilian population ratio in the country generally. These figures, however, do not represent entirely individuals but include persons licensed in more than one state during a given year, nor does the total represent additions to the medical profession, since a physician, who has been previously licensed in one state, may be licensed by ex-The total amination in a nonreciprocating state figure for the year 1946 and the eleven years previous was 115,503

There were noticeably high figures from the year 1936 to 1941 in the annual number of licenses issued, due to licensure of foreign graduates. In the succeeding years, the accelerated program in medical colleges in this country probably accounted for the number of increases in those annually licensed. In 1946, there were 1,015 more licenses issued by endorsement than in the year 1945. In the year 1946 7,605 were examined, 6,853 passed and 752 failed. These candidates were from 69 approved schools in the United States, 9 approved medical schools of Canada, and 86 faculties of medicine and 4 licensing corporations in other countries, 6 medical schools, now extinct, and 6 unapproved institutions, as well

as 7 schools of osteopathy

For the convenience and the acceleration of issuing licenses during the war period, examination dates and reciprocity meetings were scheduled by state examining boards more frequently than usual to facilitate the physicians resuming private practice of medicine. This emergency method is to be commended greatly

Of the 7,605 candidates examined, 6,288 graduates were of approved medical schools in the United States, and of these only 3 1 per cent failed. Of the 135 candidates graduating from approved Canadian medical schools, 12 6 per cent failed. Of the 68 candidates graduating from medical schools, which are not operating now, 7 3 per cent failed. Of the 494 candidates of faculties of medicine in countries

outside the United States and Canada, 55 5 per cent. failed These statements are particularly significant showing the higher standard of education in the ap proved schools in this country and Canada, hundred twenty graduates of unapproved institu tions had a failure of 41 6 per cent.

During the war, legislation was passed in New York State Ohio, and Virginia which accounted for the increase in the total number of graduates of unapproved schools tested for licenses In New York

State this has now been rescinded.

The greatest number of graduates from any one school was 348, from the University of Illinois Col lege of Medicine.

Thirteen schools had no failures before medical licensing boards. Thirty-five schools had less than 5 per cent and fourteen schools had between 5 and 10 per cent failures. Seven schools had 10 per cent or more failures. The highest percentage of failures of graduates of any one school was 31 6 per cent.

It is also noted that three out of five homeopathic boards now in existence examined only 10 candidates. It is further noted that 620 graduates of unapproved and esteopathic schools were examined, of which group 362 passed and 258 failed or 41 6 per cent. Foreign schools and unapproved schools present the greatest percentage of failures-51.5 and 416

per cent respectively

It is also noted from the various tables presented in the Journal of the American Medical Association that in some schools having high percentage of failures before state licensing boards there are very few if any failures before the National Board of Medical Examiners. This is explained by the fact that apparently the best students tried the National Board examinations while the poorer students (scholasti cally) tried only the state board examinations of the state in which they wished to practice. For illustration, there were 6 288 graduates of approved medical schools in the United States examined by the state boards with 120 or 31 per cent failures In the same period, 1,588 graduates of these same approved schools took Part III of the National Board of Medical Examiners examinations and only 21 or 1.8 per cent failed

The total number of graduates examined before the medical licensing boards of the United States in 1946 was 7 605 of which 6 853 passed and 752 or 9 9 per cent failed. In both state boards and national board examinations, 9 237 were examined, of which 8 464 passed and 773 or 8.4 per cent failed Practically all the state examining boards required the applicant to receive a general average of 75 per cent and at least 50 per cent in any one subject Some states insisted on 75 per cent in each and every sub-ject, such as our own New York State In New York State 27 physicians failed who had

received their education in New York State.

New York State also had 57 failures of graduates who had graduated from approved medical schools

in other states

In Florida, where there is no medical school 59 Florida has no or 14 3 per cent out of 414 failed reciprocity or endorsement provision whatsoever and every physician must take a written examination for licensure In 1940 417 were licensed who have failed before and were from approved schools were 646 failures of all types and 16 129 physicians licensed to practice medicine. One hundred sixty four graduates of foreign faculties of medicine and 75 graduates of unapproved institutions were licensed after previous failure

In considering registration by reciprocity and en-

dorsement by various states there appears to exist such a great variety of standards of requirements that your Committee feels they would respectfully refer you to the Journal of the American Medical Association of May 17 1947, for a more critical study of this situation. It will be found that the tables are quite complete and all the numerous questions which might be discussed can be answered from them.

Again it is noted that 9,570 physicians were granted licenses in 1946 to practice medicine, without written examinations but on the basis of licenses issued by other states, the District of Columbia and territories and possessions or foreign countries the certificate of National Board of Medical Ex aminers, or one of the government services. This number exceeds the number of any previous year by this same method. In 1945 only 3 615 licenses were issued in this manner The increase of 1946 can be accounted for by the fact that the medical officers returning from service are locating in practice in states other than those in which they had practiced before entering military service

Medical licensing boards of the United States per mitted physician-veterans to resume practice soon after separation, with almost universal recognition of former state licenses. This would account for the change in location and we think this is very com

mendable

New York State resued 1,081 such certificates. New York State certified 754 who presented a National Board of Medical Examiners Certificate

Forty physicians, legal residents of Pennsylvania qualified to take the state board examinations but who were prevented by their entrance into service with the armed forces, were licensed without ex-amination in the State of Pennsylvania, under the provision of Act 152 of the State of Pennsylvania, which was approved April 5 1945

Forty three osteopaths were licensed without examination in Delaware District of Columbia, Indians, Ohio Oregon, Wiscomin, and Wyoming

There were 6 959 additions to the medical profession in 1946 because of the 16 129 licenses issued in the year 1946 9 170 had previously been licensed, however The physician population in the United States was increased only by 3 601 as 3 358 physicians died or were located in foreign countries. The physician population has increased considerably be-cause of returning medical officers New York State had the greatest number of licenses issued for the first time, 768.

In the last 12 years, 73 612 physicians were added to our profession in the United States. It is esti-mated that as of March 15, 1947 the number of physicians in continuntal United States and in military service was 197 605. However this does not represent the practicing physician manpower of the country, as many physicians are engaged in re-search teaching, and administrative positions and others have retired

The Council Committee on Medical Education and Hospitals of the American Medical Association has agreed on certain recommendations (on high school and college credits for voterans) in a statement made in the Journal of the American Medical Association of May 17 1947 page 273

There are ten medical schools in the United States requiring an internship before an M.D. degree is issued. There are 29 licensing boards who require one year internship before a license is granted. greatest number of foreign graduates of faculties of foreign countries examined by any one state in 1946 was 315 This was in New York State Of these 106 passed and 209 failed, a failure percentage of

66 3 per cent
The next greatest number tested by any one state
was 42 It is to be noted that the foreign graduates
began to increase after 1936, and that in 1940
there were three times as many as in 1936 Since
1940 there has been an annual decrease, although
there was a slight increase in 1946 over 1945

For more minute details and statistics on a national basis, we again refer the reader to the Journal of the American Medical Association of May 17, 1947, where much detail and many well organized charts are to be seen concerning specific conditions, and an elaboration of statements previously made

The Committee in considering basic science laws has been impressed, after reviewing the various reports of basic science boards as found in the table in the Journal of the American Medical Association, page 283, and believes that the additional examining boards in the form of basic science boards are stumbling blocks, particularly to physicians seeking endorsements, due to the fact that there seems to be very little agreement among the various boards as to what the basic science law requirements should be

It would seem that where there are basic science boards, there are, of necessity, multiple examining boards for the licensing of practitioners of medicine, and it has been the experience, in the past, that this is conducive to a situation which is much more comples then a single examining board.

plex than a single examining board

It is to be remembered that the basic science boards are lay-controlled, that they assume an importance as to licensing medical practitioners that they are not entitled to, which adds to the confusion Therefore, it would appear that they defeat their own purpose in many instances

Specifically, may we remind you that in our own State the Board of Medical Examiners of the Department of Education covers all the basic science subjects in their examinations. As far as New York State is concerned, a basic science board would merely be a duplication. And then there is the possibility, as has happened in other states, that your basic science board, dominated by laymen, would attempt to become more powerful than the State Board of Medical Examiners. Again, that is bad

It is further called to your attention that the basic science boards present many obstacles to endorsements or reciprocity. We further are impressed with the suggestion that they definitely help the various cults by giving them the opportunity of treating the human body, and in our opinion, therefore, this is most undesirable

We would further call your attention to the fact

that in some reports on the basic science law that have been given to our Society in times past, that reports and statistics were obtained from the secretaries of the basic science boards and not from the medical examining boards as well

In New York State, a medical graduate in order to be licensed to practice medicine must first pay a fee of \$25 and submit evidence, verified by oath, that he

(1) Is 21 years of age, a citizen of the United States or has declared his intention to become such a citizen

(2) Is of good moral character

(3) Has, prior to beginning the first year of medical study, had the preliminary general education required by the Department of Education, namely, a Medical Study Certificate which is issued after certain requirements are met

(4) Has completed the required courses and the

required period of time in medical subjects

(5) Has received a degree of Bachelor or Doctor of Medicine from an approved medical school or foreign medical school, whose professional standards meet the New York State Board of Medical Ex-

aminers' requirements

New York State does not have reciprocity with other states at the present time, but does endorse licenses of other states when the Board of Regents is satisfied that the requirements of the other state are at least equal to those of the State of New York's Board of Medical Examiners For example, many states approve automatically the certificate of the National Board of Medical Examiners for licenses to practice medicine, but New York State does not Unless the medical graduate has passed with a grade of 75 in each and every subject, instead of just having attained an average of 75 in all his subjects, he is not endorsed We, of the

Committee, commend this practice
Looking over the reports of the New York State
Board of Medical Examiners for January, 1946,
June, 1946, October, 1946, February, 1947, and
June, 1947, we are impressed with the great number of foreign medical graduates examined and have
noted that the percentage of failures in this group is

very high (See Tables 1 and 2)

TABLE 1—Reports of New York State Board of Medical Examiners January 1946 to June 1947

MEDICAL EXAMINERS	JANUARY 1946 TO JUNE	1947
Schools	Passed	Failed
New York State schools	154	67
Other schools	223	200
Canadian schools	40	24
Foreign schools	206	618 167
Unapproved schools	192	107

TABLE 2 - REPORTS OF NEW YORK STATE BOARD OF MEDICAL EXAMINERS

	Candi	1946 idates	Cand		Octobe Cand	idates		dates	June Candi	1947 idates Failed
School	Passed	Failed	Passed	Failed	Passed	Failed	Passed	Failed	Passed	FRIIEU
Albany	0	0	0	0	0	1	1	0	2	Ō
Buffalo	ī	Ö	i	0	Ō	Ō	$ar{2}$	Ó	0	Ō
Columbia	4	Ó	4	0	0	0	Ō	2	3	2
Cornell	3	0	7	0	0	2	4	0	4	0
Long Island	4	0	7	2	8	2	7	2	6	7
New York	ī	2	2	2	0	2	2	4	0	3
New York University	7	2	9	3	5	2	4	2	13	8
Rochester	1	0	3	2	4	1	3	4	7	2
Syracuse	3	3	6	2	3	1	5	5	8	<u> 2</u>
TOTAL N Y SCHOOLS	24	7	39	11	20	11	28	19	43	19
Chicago	5	3	16	7	25	8	14	9	9	5
Middlesex	3	14	30	29	33	37	36	36	21	19 58
Other U S Schools	35	29	56	26	35	25	36	62	61	58
Canadian	5	5	8	2	6	7	10	7	11	3
Foreign	25	116	39	124	44	104	53	141	46	133
TOTAL	97	174	188	199	163	192	177	274	191	237

These failures of foreign graduates it is to be noted, have been from 70 to 82 per cent in the foregoing chart. This is not unusual for this particular period as it has been true among the foreign medical graduates for some time in the past. The reason would seem to be that the foreign medical schools are not musting on the same high standards of education as our American medical schools.

For instance, in Germany we are informed, the medical educational requirements are very low. It is stated that out of 32 000 students, 27,000 are medical students. This is the result of the low scholastic requirements which provail and the fact that the professors in Europe are paid on a per capita basis and, therefore the requirements are kept very low Ability to pay for the education seems to be the

most prominent requirement.

The Department of Education of our State believes that there will continue to be a large influx of foreign physicians because of the unsettled condi-tions in Europe It is stated that they will arrive as fast and as soon as they are able to obtain visas We understand that it is the policy of the Department of Education of the State of New York that they will not endorse any foreign medical graduate nor will they admit to medical licensure examination any foreign graduate who has matriculated in medi-cine after January 1, 1940. This decision has been brought about by the war which has resulted in very poor medical education being given in foreign countries. The information on which this decision is based is sound, having been proved by the medical officers of the Army who have made a thorough investigation of all foreign medical schools

The special regulation concerning credit for serv ice in the Army must have been started before January 1 1947 in order to be recognized in our

State.

New York State does not now require an intern

ship for license

It is to be noted that the number of physicians registered in New York State has increased in the past two or three years. This is undoubtedly due to the fact that separated service medical officers have decided to locate in New York State because of the excellent hospital facilities of our State

In 1939 the Department of Education had all legislation concorning reciprocity agreements repealed. The Department of Education now inquires into the requirements of every state and endorses only those licenses whose state requirements meet

our own.

The Department of Education has set up a special committee on endorsements whose duty it is to see that all requirements are met before a license to practice medicine is endorsed. A further policy of the State of New York Department of Education is that no more foreign graduates can be endorsed They all must be examined

In considering the question of licenses for chiropractors in this State we are aware of the many pamphlets pro and con that have been distributed and we are firmly convinced that chiropractors should not be licensed to practice the healing art (in medicine) because of their inadequate education and lack of knowledge of the human body as well We are all of the opinion that as science in general if they wish to practice medicine they should study the regular medical courses in a regular medical school

The Committee would further like to call your attention to the fact that although chiropractors are not licensed to practice as such in this State, the Veterans Administration is now paying for the training of servicemen as chiropractors in some 16 chi ropractic schools also they are paying for veterans who are studying in foreign medical schools Neither class of these can be beensed in New York State and therefore cannot practice here We were informed that this was brought to the attention of the assist ant administrator of Vocational Rehabilitation Fa culities

We recommend, in prosecuting illegal practi tioners of medicine that the injunction law be in voked and used more often than at present action would help stop the chiropractors and members of various other cults, because the offenders would then be tried by a judge instead of by a jury which is often sympathetic to a cultist.

Office Administration and Policies.-This special committee of the Society consists of

John J Masterson M.D Chairman Brooklyn New York City New York City W P Anderton, M.D. Dwight Anderson James R. Reuling M D Bayside Laurance D Rodway, M D George W Kosmal, M.D Ossining New York

The Office Administration and Policies Committee has met almost monthly during the past year of the many accomplishments under the supervision of our Committee was moving the office of the Medical Society of the State of New York from the twenty-first and sixteenth floors to the seventh floor of 202 Madison Avenue on November 15, 1947 This has resulted in concentrating most of the work of the Society and in an increase of efficiency

Last June, Mr Thomas E. Alexander was engaged as chief accountant for the State Society Last October with the approval of the Board of Trustees it was voted to have an annual physical examina-tion, chest x ray and blood count and Wassermann

when indicated, for each employe

Pursuant to the recommendation of the 1947 House of Delegates acting on the Supplementary Report of the Board of Trustees, that the Committee on Office Administration and Policies study and report on conducting the management and administrative affairs of the Society in the most efficient manner possible, a number of improvements have been instituted by this Committee, and, from time to time reported to the Council The following is a **Jummary**

(1) A new and improved bookkeeping and filing system has been installed in the accounting depart

(2) Payroll operations have been improved by installing the 'Hadley Payroll Plan' the use of which facilitates employe salary records and sim plifies tax reports.

(3) A triplicate purchase order system has been

installed.

(4) A uniform invoicing procedure with car bons, has been installed with advantages in accounting control and inventory

5) Stationery and supplies have been placed in the hands of one person who is in charge of this part of the stock room and to whom requisitions for supplies must be made (6) A postage meter has been installed and pro-

cedures developed for charging postage used to the

various departments

(7) Directory billing and collections on advertising and volume sales have been integrated with the accounting function to correct defects which existed in handling these matters as a separate operation from accounting with the issue of the 1947 Directory

(8) Procedures have been instituted for recording the of time arrival of employes in the morning and departure at night, also absences during working hours have been subject to scrutiny and have been reduced to what is considered to be a reasonable minimum

(9) Telephone calls have been limited to six personal calls per month A system has been installed for checking toll calls and long distance calls soon after they are made and for proper charging to various departments, or to the person making

(10) A study has been made of the qualifications and experience of each employe, and the requirements of each position From this job analysis, it appears that in our office many of these positions are highly specialized, due to the Society's needs both for professional background and knowledge, on the one part, and business or commercial skill in procedures on the other. It appears madvisable at this time to attempt to standardize and rate clerical jobs in a formal job classification which might call for identical salaries in various arbitrary grades throughout all departments Especially is this true under employment conditions which exist at the

present time

This business survey of the Society's office operations will continue, and other improvements will be instituted as they appear to be desirable. The Committee has studied the suggestion offered "That a business survey be made of the greatly extended activities of the Society during the past eight years by a competent firm or other qualified persons" Inasmuch as such a study has now been made by this Committee, and action taken to effect improvements has been reported upon to the Council, it is believed by the Committee that it is not necessary or desirable to go to the expense of employing outside persons to make such a survey It was recom-mended that this be the action of the Council, pursuant to the recommendation of the House of Delegates, "for study and such action as may be deemed appropriate" Your Committee respectfully recommends that the House of Delegates continue this special committee under supervision of and reporting to the Council

Nursing Education —The Committee on Nursing Education has the following membership

W Guernsey Frey, M D, Chairman

New York City New York City W P Anderton, M D Norman S Moore, M D

The Committee continues to represent the Society on the Coordinating Council for Nursing Problems (with representatives of the New York State Hospital Association, the New York State Professional Nurses' Association, and the Practical Nurses of New York) Two meetings of this body and one meeting of its executive committee have been held since the 1947 meeting of the House of Delegates

The Coordinating Council on Nursing Problems has encouraged the setting up of similar coordinating committees on the county level, and, in instances where such local bodies were already functioning satisfactorily, has recognized the existing

Support has been given to proposed legislation for the licensing by endorsement of professional and practical nurses who hold licenses in other states and Canadian provinces, and to the admission to licensing examination of nurses who show qualification by graduation from out of state accredited schools or by practical experience Efforts to further the recruitment of student nurses, both prac-tical and professional, male and female, have been encouraged.

The Council also considered such matters as retirement plans for nurses, the extent of professional activities permitted practical nurses, and the part the medical profession might play in relieving the nursing burdens It was recognized that the present nursing problem is a result, not of a numerical shortage of nurses, but of changed and far more complex methods of caring for the sick during the past few decades, together with a shortened work week, and increased use of hospital facilities and

trained personnel in caring for the acutely ill and

the chronically ill It was suggested that the medical

profession give thought to how the various classes of nursing attendants may be employed to the greatest advantages, in general as well as in individual cases

The Coordinating Council on Nursing Problems continues to exercise a most valuable function in public relations, differences, mainly in viewpoint, between the representatives of the several sponsoring bodies have been discussed thoroughly and in The Council is every case amicably adjusted grateful for the cooperation of the State Education Department and other interested organizations whose representatives have sat with it by invitation from time to time

Woman's Auxiliary —The Council Advisory Committee on Woman's Auxiliary consists of the following personnel

Fenwick Beekman, M.D., Chairman

New York_City Bronx

Nathan B Van Etten, M.D Elton R Dickson, M D Binghamton

As 1947 ended, your chairman took great pleasure in preparing a report on the activities of the Woman's Auxiliary to the Medical Society of the State of New York.

While the individual accomplishments of each county auxiliary, to say nothing of the activities of each single member, would take too long to narrate, we feel that we cannot pass over them without, at the outset, reminding you that the State organization is but the depository of the deeds of the county auxiliaries, and, in turn, the counties of the acts of the individual Accordingly, you will understand that what we report of the State organization applies equally to each county and to each individual member

The most outstanding accomplishment was the organization of three new county auxiliaries, which now gives us a total of 42 counties, in which the four activities suggested by Dr Bauer are now fields of action, and in which we can be certain that our colleagues have at least one other voice, in addition to their consciences, urging them to participate in the activities of their county society's public relations, legislative and voluntary medical care programs

The circulation of the Auxiliary publication, the Distaff, also reflects the growth of the organization. The demand for the winter edition exceeded 3,200 For this work we are indebted to Mrs Lee R Sanborn, its editor Another activity which merits our gratitude is the Auxiliary's promotional efforts in behalf of voluntary medical care plans, as directed by Mrs Alfred F Madden

The three outstanding events of the year were

the Annual Convention and the fall and winter

executive board meetings

Three activities in which the Auxiliary has been especially active are the endowment of nurses scholarships, collection of funds for the Physicians Home and the education and enlightenment of the general public to the danger of chiropractic. The last activity which is so important if the public is to continue to enjoy the present standards of medical care would appear to have to be a full time job in itself. The response the members made to suggestions contained in the bulletins on chiropractic, pre-pared during the Legislative session by the Public Relations Bureau for their guidance, was surpassed only by their scal in behalf of medical care plans.

As an example of the industry the members display, we shall enumerate only a partial list of the president a itinerary so that you may better under stand how the Auxiliar, is able to keep abreast of as many developments as it does.

During the year 1947 Mrs. Harry F Pohlmann president, attended the following functions

13 county meetings

3 newly organized county meetings

1 reorganized county meeting

5 District Branch meetings

1 meeting with Advisory Council and board members

4 conferences with Dr Fenwick Beekman

2 conferences with Mr George Farrell 6 conferences with Mr Thomas E. Walsh 1 conference with Mr Dwight Anderson

1 convention at Pittsburgh (Pennsylvania State)

1 convention at Atlantic City (New Jersey State)

1 convention at Atlantic City (A.M.A.)

1 executive board meeting at Port Jervis I conference of state presidents and presidentselect at Chicago

4 conferences with eight councilors

2 conferences with our 15 Standing Committees chaumen

2 conferences with our 36 county presidents

From what is contained in this report, but mainly from the intangible items which are too difficult to record, your Committoe wishes to point out that we look upon each county auxiliary as a partner of the parent Society We feel that each auxiliary can be depended upon to keep in touch with non scientific developments in the medical world, and to act as the eyes and ears of the parent organisa-tion. Thus they serve to keep the State Society ad vised of the methods by which the people in the several counties evaluate the parent organization and the services rendered by our members.

In conclusion, we wish to compliment the presi dent, Mrs Harry Pohlmann, each of her officers each county officer and each individual member on the energy they display in accomplishing their goals and for the spirit of harmony understanding. and good will that they have developed, among thomselves, with our liaison officer, Mr Thomas E Walsh, and with each member of the Advisory Council

Convention.—The Council Committee on Convention consists of the following members

Harry Aranow M.D., Chairman W P Anderton, M.D Bronx New York City Dwight Anderson Now York City

The 141st Annual Meeting of the Medical Society of the State of New York tool place at Buffalo from May 5 through 9 1947 The Civic Memorial Auditorium was the headquarters

Attendance was as follows

Membera	1 310
Guesta	25-
Exhibitors	401
Total	1 97

A special Teaching Day program was arranged by the Committee on Public Health and Education Dr O W H Mitchell chairman for Tuesday

May 6 This was well attended.

In the Scientific Program, approximately one hundred and twenty five papers were read general sessions were well attended. The joint meeting of the Section on Medicine and the Section on Surgery drew a large attendance for the panel discussion on peptic ulcer. The round table discussion on cases of proved chest pathology in the Section on Radiology evoked a lively discussion The Section on Anesthesia presented a symposium on the use of procaine intravenously the Section on Dermatology and Syphilology, a panel discussion on syphilis, the Section on Urology a symposium on bladder tumors. All of these proved of much in

The space available for the Scientific Exhibits was larger than in previous years This allowed a greater number of exhibits and more space for each one than in former years. The exhibits were well presented and well attended by members and guests. The Scientific Award Committee awarded a first prize, a second prize, and honorable mention in two classes clinical and scientific

The Technical Exhibits were also well attended The Banquet and Annual Meeting at the Statler Hotel was attended by approximately four hundred people A feature of the banquet was the presenta-tion of certificates to members of the Society who had been in practice for fifty years or more.

Seventy-one members were guests of the Society

and took part in this coremony

The Woman's Auxiliary had rooms at the Statler Hotel for all their activities. The ladies expressed pleasure at the facilities provided for them
After considering bids from the Hotel Waldorf

Astoria and the Hotel Pennsylvania, New York City last summer arrangements were made to hold the 1948 Annual Meeting in the Hotel Penn-

sylvania

Last October the Convention Committee met at the Hotel Pennsylvania, New York City This meeting was well attended by members of the Subcommittees on Arrangements, Scientific Program, Scientific Exhibits, Scientific Awards, and officers of Sections and Sections Many of the Session and Section programs were in readiness at that time Where more than one program had papers on similar subjects the situation was adjusted. The meeting was constructive and cooperative.

We are anticipating a successful 1948 Annual Meeting. The New York Convention and Visitors Bureau, Inc., and the hotels in the neighborhood of the Hotel Pennsylvania are cooperating. The Scientific and Technical Exhibits are well planned, and the programs for Sessions, Sections, Teaching Day and general meetings, are of very high quality

REPORT OF THE COUNSEL

To the House of Delegates, Gentlemen

Your Counsel herewith submits the annual report of the activities of the Legal Department of the Medical Society of the State of New York for the period from February 1, 1947, to and including January 31, 1948

In making this report it is necessary for the sake of brevity that most of the work must merely be outlined, for space does not permit an elaborate discussion of what has been done by our Depart-

ment

During the year there has been no change in the personnel of your Counsel's legal staff Mr Thomas H Clearwater and your Counsel have continued their practice of law as the firm of Martin & Clearwater Mr Clearwater has been Attorney for the Society for nearly eighteen years and is known to the members of the House Mr Robert J Bell who has been associated with your Counsel and his predecessor since 1931, except for the years of his service in the Navy, continues his good work in the handling of malpractice cases, and during the past year has engaged in a greater amount of actual trial work than previously Mr John J De Luca likewise has continued as a valuable member of the staff Special mention should be made of the fact that Mrs Agnes C Van Horne, my chief clerk, and Miss Florence M Jackman, telephone operator, have been associated continuously with my office for over two decades and continue their loyal and untiring work

In reporting to the House, your Counsel again adheres to the catagories followed in previous years, namely (a) the actual handling of malpractice suits and claims, (b) counsel work with officers, committee and individual members of the

Society, and (c) legislative activities

Litigation —Your Counsel and his predecessors in many previous years have taken occasion to point out to your Society the dangers of hasty, careless, reckless, and often unfair comment by one physician concerning the work of another. Such injudicious remarks frequently give rise to malpractice actions, even though they are not intended to do harm to the other physician. On many occasions it takes but little to stimulate such litigation, and it has long been felt that if doctors were more judicious in their conversations with patients much malpractice litigation would be avoided

We again call attention to the ever continuing hazard to the practicing physician of becoming involved in a malpractice action. The hazard is just as real to every physician, whether he be a general practitioner, or any sort of specialist. These cases are often tried before juries of laymen who may be swayed by sympathy, bias, passion, or prejudice, although in theory such elements should not in-

fluence the outcome of litigation

The wisdom of a doctor conducting his practice in such a way as to protect the record is apparent Consultants should be called upon where needed, ample x-rays taken when indicated, and complete and accurate office or hospital records are imperative. Malpractice cases may not be determined for a period of years, and the corroboration of a defendant physician, by documentary proof and by witnesses to the facts, can in many instances prevent a physician from being the victim of a patient's distorted version of the facts.

It should be noted that, with rising costs of living, the expense of disposing of malpractice cases has likewise gone up. The sharp increase in hospital costs, the rise in average wages, and the general high cost of living are all elements which go into the appraisal of the value of a malpractice case when settled, or in the event a court or jury awards damages against a doctor

It should be noted in this connection that the Society has for many years sponsored a Group Plan of insurance, the efficient operation of which has continued. The Society provides through your Counsel, without charge, defense to members who carry no such insurance. Although a great percentage of members are so insured, each year a number of physicians find themselves in the undesirable position of being defendants in malpractice actions with no insurance protection whatever. During the reporting period, the defense of twenty-one such uninsured members was undertaken by your Counsel in new cases instituted during those twelve months. Obviously those physicians regret that they failed to take advantage of the Group Plan, which ments the loyal support of every member of the Society.

The Yorkshire Indomnity Company has been the carrier under the Group Plan for over twelve years, and it has continued to meet all of its obligations to its assureds and to cooperate fully with your Counsel in every way in the handling of cases covered. We express our appreciation to Mr. Horace Crowell, Jr., secretary of the Company, in charge of its claim department, for his efficient and cooperative work, and also to his subordinates, particularly Mr. Lawrence S. Cunningham, who has been known for

years to many members of your Society

Two years ago the House of Delegates created a special committee known as the Malpractice Insurance and Defense Board, which has continued its dilgent efforts under the able and untiring work of its chairman, Dr Thomas M D'Angelo Its many meetings have been attended by your Counsel and Mr Clearwater The advantage to the Society of the Board as now constituted is great, for it includes doctors representing various sections of the State, and the term of office of its members is sufficiently long to enable them to become fully familiar with the complicated problems which come before them for consideration

With these preliminary statements we note that during the present reporting period there were 153 new actions commenced. This shows a considerable increase over the 125 actions reported during the preceding year, but it is still no greater than an average prewar year No prediction can be made as to whether or not the ensuing months will bring a still further rise in the number of cases instituted In addition to the 153 cases mentioned, there were also a considerable number of claims made during the reporting period, some of which have been dropped after conference, or settled before suit, but some of which may eventuate into litigation are often in consultation with claimants or their attorneys, and frequently are successful in convincing them of the lack of merit in their claims, so that many such claims will never actually become law-

Table 1 shows that during the present reporting period we have disposed of 105 cases—Sixty-seven

of these cases were settled and 87 terminated successfully in favor of the physician In but one case was there a judgment for the plaintiff against a doctor

There were pending, at the end of the reporting period somewhat over 400 cases many of which are entirely dormant

TABLE 1 -- NUMBER OF SUITS INSTITUTED

	AND DISPOSED OF II	1841-1849	
12245 6789	Fractures etc. Obstetrics, etc. Amputations Burns -ray etc. Operations, abdominal eye, tonail, sar etc. Needles breaking Infections, Lys infections Duagnosis	Instituted 1947-1948 (1° months) 11 23 1 16 39 7 13 4	Disposed 6 1947-194 (12 month 1 1 14 41 41 5 2
10 11	Lunacy commitments Unclassified—medical Total	29 153	17 105
Infe	ions for death ints actions OTAL	22 17 39	1 9 21
	How Dispes	ed of	
_ p	iled minated in favor of defendant hysician gment for plaintiff		07 37 1
	OTAL		105

Counsel Work.-During the period of this report your Counsel and Mr. Clearwater have attended the Annual Meeting of the Society and the regular meet ings of the Council and Board of Trustees, and have conferred with members of these bodies, and with members of Committees upon numerous legal problems that have arisen

Your Counsel prepared the contracts which are now in effect between the Society and Dr Robert R Hannon Dr David J Kaliski and Mr George P Farrell and prepared the contracts entered into with the Society's auditors We have participated in certain legal problems attendant upon the So-ciety's removal of its offices to its present enlarged quarters

Your Counsel acting with the Committee on By laws, has examined a number of proposed changes to the Constitutions and Bylaws of a number of component county medical societies, and has ren-dered advice and made suggestions in connection therewith

We have been in frequent consultation with Dr Anderton Dr Kaliski and Mr Anderson relative to legal phases of problems which have arisen in their particular fields of work.

During the reporting period your Counsel and Mr Clearwater have appeared before a number of medical societies and other groups of doctors and addressed them concerning medicologal problems arising out of the practice of medicine. Such talks have been given in New York Binghamton, Sara

toga, Albany Amsterdam and Brooklyn
Your Counsel receives frequent requests orally and in writing for opinions from various members on a wide variety of topics. A few of the matters on which such advice has been given during the past year include the following legality of partnerships between physicians, propriety of use of surgical materials experimental in character, right of phy sician to employ an unheomed medical school graduate, legality of sterilization operation, legal problems of artificial insemination consequences of failure of licensed physicians to register properly under the Education Law, consequences of revoca tion of license to practice, residence requirements relating to employes of New York City Hospital system, right to recover fees for services not ac-tually performed legal consequences of operations performed by junior surgeons under supervision, incorporation of county medical society, right of county medical society to enforce payment of special assessments, right of physican to market a pat-ented surgical instrument legal status of optometrists and opticians legal status of esteopaths legal consequences of physician a temporary absonce from practice, duty of physicians to honor service of subpoens.

It should be noted that your Counsel s office is at the service of all members of the Society, and it is a daily occurrence for us to be consulted either by personal inquiry or by telephone concerning the legal problems arising out of emergency situations which must be dealt with immediately We endeavor to render guidance and assistance in such enses which actually involve a considerable amount

of time and work

Legislative Advice and Activities.-During the reporting period, your Counsel and Mr. Clearwater have conferred with numerous persons in connection with proposed changes in the law which affect the practice of medicine and the medical profession buch problems have been discussed at length with the Society's officers and committeemen with Dr Hannon the Executive Officer, and with Mr Ander son and Mr Thomas E. Walsh Mr Clearwater attended the annual meeting of the Council Committee on Legislation with the chairmen of the County Society Logislative Committees at Albany On a number of occasions he also conferred concerning proposed legislation with representatives of the hospitals and of various medical specialties.

Conclusion —In closing, your Counsel wishes to express his appreciation for the work of his own staff and for the advice and assistance of your Society's members throughout the entire State, who have helped us both in and out of Court, in consulta tion and in the defense of malpractice actions officers of the Society and the members of the Council and Board of Trustees have been of great help Such cooperation has enabled your and assistance Counsel to obtain the results shown in this report

> Respectfully submitted WILLIAM F MARTIN, Counsel

REPORTS OF THE DISTRICT BRANCHES

First District Branch

To the House of Delegates, Gentlemen

On June 19, 1947, a meeting of members of the executive committee and presidents of the component county societies of the First District Branch was held at Hotel Gramatan, Bronvville, for the purpose of arranging time, place, and program for the annual meeting of the District Branch

The forty-first annual meeting of the First District Branch was held on October 30, 1947, at the Veterans Administration Hospital, 130 West Kingsbridge Road, the Bronx, when the following program was presented At the morning session, from 9 00 to 12 00, an operative surgical clinic was held, and from 10 00 to 12 00, a medical clinic with presentation of cases At noon, a buffet luncheon was held, followed by a panel discussion on public relations, with Louis H Bauer, M D, moderator, and Mr Dwight Anderson, Stephen R Monteith, M D, and M Renfrew Bradner, M D

The afternoon session from 2 00 to 4 00 included a panel discussion on treatment in hypertensive renal disease. Taking part were Scott Lord Smith, M.D., moderator, and Arthur M. Fishberg, M.D., Herbert Chasis, M.D., and Bronson S. Ray, M.D.

This is the second year that the Veterans Hospital has acted as host to the First District Branch at its

annual meeting

The registered attendance was 115, of which 10 were not members of the First District The usual attendance for these meetings is not far from this This raises the question of the usefulness of the Branch meetings, at least in the Metropolitan area

I wish in behalf of the First District Branch to extend thanks to the Veterans Hospital and staff for their hospitality and the fine surgical clinic which was staged at the time of our meeting Dr Hannon m his usual modest but efficient manner took charge of all the details of organization

> Respectfully submitted, H F Morrison, M D, President

February 16, 1948

Second District Branch

To the House of Delegates, Gentlemen

The forty-first annual meeting of the Second District Branch of the Medical Society of the State of New York was held on October 29, 1947, at the

Garden City Hotel

The morning session was devoted to a panel dis-The morning session was devoted to a panel discussion on "The Management of Gastrointestinal Problems of the Upper Abdomen," with Dr Albert F R Andresen, Brooklyn, as chairman The panel consisted also of Drs Frank Glenn, New York City, Edward Weiss, Philadelphia, A L Loomis Bell, Brooklyn, John Russell Twiss, New York City, and Burrill B Crohn, New York City The panel discussion was received favorably, and it is planned to cussion was received favorably, and it is planned to hold more of this type of meeting in the future

At luncheon we were joined by the woman's

auxiliaries of the four counties and were addressed by Dr Louis H Bauer, president of the Medical Society of the State of New York, and Mrs Harry F Pohlmann, president of the Woman's Auxiliary to the Medical Society of the State of New York

The day's session was closed by an excellent address on "Herniation of Intervertebral Disks Cervical and Lumbar" by Dr Jefferson Browder,

Brooklyn

The meeting was attended by 201 physicians, including 51 from Kings, 76 from Nassau, 35 from

Queens, and 27 from Suffolk

It was a pleasure to have with us Dr W P Anderton, Dr Werner Nobel, Dr Armand J Prisco, Mr Dwight Anderson, Mr. George P Farrell, and Mr Thomas E Walsh of New York City, Dr Laurance D Redway, Ossining, Dr Robert R Hannon, Albany, and Dr Richard R Ferayorn, Rochester, Minnesota

The Branch agam is indebted to its efficient secretary-treasurer, Dr Charles F McCarty, for

arranging the luncheon

Respectfully submitted, JOHN B D'ALBORA, M D , President February 16, 1948

Third District Branch

To the House of Delegates, Gentlemen

A meeting of the officers and presidents of the Third District Branch was held at the Governor Dr Hannon, Clinton Hotel in Kingston in June our executive officer, cooperated with these groups at this meeting when plans were made for a scientific program to be held at the Grossinger Hotel in Ferndale Dr Harry Golembe, our first vice-president, and Dr Ralph S Breakey, president of the Sull and County May 1 See 1 See 2 Sullivan County Medical Society, were appointed as a committee to arrange for the Annual Meeting, and they are to be commended for their excellent planning

The officers and members of the Third District Branch were gratified by the attendance at the meeting and by the interesting and varied program It appealed to our members and guests Dr Louis H Bauer, our genial and able president, was present and delivered a splendid message to us at the luncheon For several years we had entertained some doubts as to the success and the advisability of continuing the District Branch Meetings, but the past two or three years have encouraged our officers to a great extent. It would seem that an Annual Meeting of seven neighboring county societies should be very worth while, both from the standpoint of a scientific program and also from the opportunity to meet and renew friendships with our colleagues whom we contact at such infrequent intervals. I hope that this attendance of ninetyone physicians will be even greater this coming

The morning scientific program included a symposium on thyroid, with the following papers presented "Malignant Lesions of the Thyroid," John C McClintock, M D, assisting professor of surgery,

"The Diagnosis and Albany Medical College, Albany Medical College, "The Diagnosis and Treatment of Diseases of the Thyroid," Donald Guthric, M.D., Guthric Clinic Robert Packer Hospital Sayre, Pennsylvania. At the luncheon Louis H Bauer M.D president Medical Society of the State of New York, was guest speaker Intheafterneon session the papers included "Streptomycin and Tuberculosis," William H Steams

M.D., instructor in modicine College of Physicians and Surgeons, Columbia University, and associate visiting physician, Chest Service, Bellevue Hospital BCG Immunication, Konrad Birkhaug M.D. Division of Laboratories and Research, New York State Department of Health, Albany and 'The Treatment of Common Skin Diseases' Timothy J Riordan, M.D., associate clinical professor of der matology and syphilology New York University College of Medicine

Respectfully submitted FREDERIC W HOLCOMB M D President March 3 1948

Fourth District Branch

To the House of Delegates Gentlemen

The Fourth District Branch of the Medical Soclety of the State of New York met on Thursday

October 23, 1947 in Amsterdam.

About eighty members of the Society were present from the counties in the northeastern part of the State

the State

The meeting was called to order at 2 30 P.M. and
Dr. David P. Boyd of Amsterdam opened the
scientific session with a paper on "The Surgical
Treatment of Hypertension," using a fresh preparation of a sympathetic nerve just removed in the
morning. The paper was discussed from the floor
Next, Mr. George P. Farrell director Bureau of
Medical Care Insurance of the State Society spoke

"The Deceant Status and Future of Medical."

on "The Present Status and Future of Medical Caro Insurance telling of the work that has been done in this important field during the past fow

Following this, Dr Robort E Plunkett, Assistant Commissioner of Health for New York State, told us of "The Use of BCG Vaccine in the Control of Tuperculosis with the latest information on this

rather controversial subject.

'Legal Difficulties Frequently Encountered by Practitioners of Medicine was the title of an inter esting informal talk by Mr Thomas H Clearwater, attorney for the State Society with illustrative legal case reports.

The surgical paper of the afternoon was delivered by Dr Charles Gordon Heyd, of the New York Post-Graduate Hospital, on Cancer of the Large Bowel and Rectum. The talk was well illustrated with lantern slides and covered much material.

The work of the Workmen a Compensation Com miltee of the State Society was presented by Dr Joseph P Henry, Rochester and Dr J Stanley Kenney New York. The question of the fee schedule has taken much time and is only one of the many problems that has come to this important committee

The ladies were entertained by the members of the Woman s Auxiliary in the afternoon, and joined the doctors for dinner at the Elks Club

At the dinner, Dr Louis H Bauer president of the Medical Society of the State of New York, gave the address. Also introduced were Dr Robert R. Hannon, executive officer of the State Society, Joseph Geis vice-president of the Fourth District Branch Mr Dwight Anderson executive secretary and director of the Bureau of Public Relations, Rene H. Juchli, president, and Dr D W Childs secretary of the Montgomery County Society, Dr Walter P Anderton secretary of the State Society, and Dr Charles Gordon Heyd past-president of the American Medical Association who spoke briefly on the work of the A M.A.

After a very enjoyable evening with music and

dencing the meeting adjourned

Respectfully submitted Denver M Vickers, M.D., Prendent February 26 1948

Fifth District Branch

To the House of Delegates Gentlemen

The forty-first annual meeting of the Fifth District Branch of the Medical Society of the State of New York was held in the Hotel Utica, Utica, on Tuesday, September 30 1947 The afternoon program was devoted to a symposium on cancer Dr Richard II Lyons professor of medicine Syracuse University College of Medicine acted as moderator The panel was composed of Dr Fred W Stewart pathologist, Memorial Hospital New York City, Dr Alexander Brumhwig, attending surgeon Memorial Hospital, New York City and Dr E L Frazeil associate attending surgeon, Memorial Hospital, New York City A large and representa tive attendance from the district heard their papers with interest and there was an active discussion.

A short business meeting was held at the con clusion of the afternoon session and the following officers were elected James E. McAskill M.D. Watertown, president Wardner D Ayer, M.D. Syracuse, first vice-president Arthur F Gaffney, M D Clinton, second vice-president Richard B Cuthbert, Jr M D Canastota, secretary and Donald C Tulloch, M D Ogdensburg, treasurer

The evening program consisted of a banquet which was attended by the doctors and their wives. An address was given by Dr Louis H Bauer, president of the Medical Society of the State of New York. Dr Herman E. Hilleboe New York State Com-missioner of Health spoke on The Future of Public Health in New York State. A twenty five dollar prize donated by the officers of the Fifth District Branch was given to the Ladies' Auxiliary of Her-Limer County who had the highest proportional representation at the meeting. There were one hundred and twenty five members of the district registered at the session

> Respectfully submitted, H D VICKERS M D President

February 3 1948

Sixth District Branch

To the House of Delegates Gentlemen

The forty first annual meeting of the Sixth District Branch of the Medical Society of the State of

New York was held October 15, 1947, at the high school auditorium in Norwich Sixty-nine members

and guests registered in attendance

The afternoon session was called to order at 3 15 PM, and the following papers were presented Louis E Daily, director of medical research, Eaton Laboratories, "Recent Clinical Experience with Furacin," and Dr Samuel E Cohen, pathologist, Arnot-Oeden Hospital, Elmira, "Polycythemic Arnot-Ogden Hospital, Elmira, "Polycythemic Anemia" This paper was discussed by Dr Ronald L Hamilton, Binghamton

A business meeting was called to order at 4 45 PM The nominating committee presented the panel for officers for 1948 and 1949 On regular motion, duly seconded and carried, nominations were ordered closed and the secretary ordered to cast one ballot for the following members as officers Charles L Pope, M D, Binghamton, president, Norman C Lyster, M D, Norwich, first vice-president, Elton R Dickson, M D, Binghamton, second vice-president, Paul F Willwerth MD, Montour Falls, secretary, and Marshall Latcher, M D, Oneonta, treasurer

Dinner was served at the Elks Club, Norwich, at 6 00 PM. The following representatives of the State Society were present and introduced. Dr. Walter P. Anderton, secretary, Dr. Robert R. Hannon, executive officer, Mr. George P. Farrell, director, Medical Care Insurance Division, and Mr. Thomas E. Walsh of the Public Beletices at all the Public Beletices at all the public Beletices at all the Thomas E Walsh of the Public Relations staff

The address was given by the president of the State Society, Dr Louis H Bauer, who discussed national problems confronting the profession

The evening program consisted of a "Symposium on Asthma" conducted by Dr Robert Chobot and Dr William B Sherman, from the Roosevelt Hospital Allergy Clinic, New York City A round table discussion of this subject concluded the ses-

Respectfully submitted, IVAN N PETERSON, M D, President December 10, 1947

Seventh District Branch

To the House of Delegates, Gentlemen

The presidents of the component county societies met on June 26, 1947, with Dr Robert Hannon, the executive officer, to arrange for the annual meeting Dr Floyd S Winslow of Rochester was also present

at this meeting

The forty-first annual meeting was held on September 25 at the Veterans Administration Hospital at Bath The program of the morning session consisted of "Primary Care of the Injured Hand," by Dr John C Detro, plastic surgeon at the Rochester General Hospital, and "The Peptic Ulcer Problem," by Dr Albert F R. Andresen, professor of clinical medicine, Long Island College of Medicine

During the noon intermission, lunch was served at the hospital, at which there were memorable addresses by Dr Louis H Bauer, president of the State Society, and by General Paul Hawley, medical director of the Veterans Administration

At the opening of the afternoon session there was a short business meeting to elect new officers for the coming term The following were chosen Dr George Kenneth Rowe, Hornell, president, Gage, Rochester, first vice-president, Dr Samuel A Mumford, Clifton Springs, second vice-president, Dr Glenn C Hatch, Penn Yan, secretary, and Dr

James J Yanick, Hornell, treasurer

The scientific papers of the afternoon were "Hypertension," by Dr Jacob D Goldstein, assistant professor of medicine and bacteriology, University of Rochester School of Medicine and Dentistry, and "Office Management of Gynecologic Complaints," by Dr Clyde L Randall, professor of gynecology, University of Buffalo School of Medicine

One hundred and seven members registered from

the district and thirteen from elsewhere

Respectfully submitted, LLOYD F ALLEN, M D, President

March 1, 1948

Eighth District Branch

To the House of Delegates, Gentlemen

The annual scientific and business meeting of the Eighth District of the Medical Society of the State of New York was held in Jamestown on October 1, 1947 One hundred members were present A scientific program consisting of the following was presented "Hypoglycemia," by Dr Edgar Beck, "The Significance of Laboratory Findings in the Diagnosis and Treatment of Disease," by Dr John H Talbott, "Symposium on Cancer Therapy The Results of Experiments and Clinical Investment of the Norer Agents in the Clinical Investigation of the Newer Agents in the Treatment of Cancer," by Dr Louis J Kress, "Advances in the Use of X-ray and Radium in the Treatment of Cancer," by Dr Walter Murphy, and "New Surgical Methods in the Treatment of Cancer," by Dr. Local E. Magnesian

Cancer," by Dr Joseph E Macmanus
Dr Louis H Bauer, president of the Medical
Society of the State of New York, was the principal speaker
His comments and advice on the need of greater and stronger efforts on the part of organized medicine to prevent any inroads of social-

organized medicine to prevent any inroads of socialized medicine, were presented most emphatically Following the noontime luncheon session, the annual election was held. The following were elected to office. Dr. Robert C. Peale, Cattaraugus County, president, Dr. John C. Kinzly, Niagara County, first vice-president, Dr. Henry S. Martin, Wyoming County, second vice-president, Dr. Ralph M. Bruckheimer, Chautauqua County, secretary, and Dr. Sydney L. McLouth, Genesee County, treasurer. treasurer

The Advisory Council of presidents and secretaries of the medical societies of the Eighth Judicial District of New York State has just completed its first year of activity The first regular meeting was held in Buffalo on February 20, 1947 Eighteen representatives of the eight county societies were present Consideration of bills before the 1947 session of the State Legislature that pertained to the direct interest or welfare of the medical pro-fession were the main topic of discussion Letters recording the reaction of the group were sent to the various State Legislators, who were sponsoring or interested in the bill Since the first meeting, the Advisory Council has met at intervals of two months. All meetings have been well attended The discussion has been free, and any action taken on matters brought before the council was a concerted one, representing the reaction of the medical profession of western New York

At the last meeting hold on February 12, 1048 the council and representatives of the Legislative and Workmen's Compensation Committees of the eight participating counties met with the Advisory Council to discuss the current bills of medical interest that were before the 1948 State Legislature

It was agreed at this meeting that the Advisory Council as a body and the county societies as individual units would acquaint appropriate committee cinirmen of the State Legislature and individual members of the Legislature from the Eighth District counties with the views and reactions of Eighth District medicine on all measures considered at this stated meeting. Such action has been taken and the response from the State Legislators has been most gratifying

It was also agreed that, at future meetings, representatives from the various county committees would neet with the Advisory Council from time to time to share opinions and act on any matters that might pertain to their respective committees

As president of the Eighth District Branch and chairman of the Advisory Council, I would like take this occasion to thank the representatives of the component county societies for their cooperation and loyal support during the first year of the Advisory Council in making it a potent factor in medical activities in western New York.

In addition, I would like also to extend the approciation of the Advisory Council for the able assistance rendered by Mr Harold P Jarvis and Mr Joseph J Guariglia of Eric County and for their generous cooperation in organization plans

Respectfully submitted, WILLIAM J ORR, M.D., President March 8, 1948

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1948 HOUSE OF DELEGATES—REFERENCE COMMITTEES

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Irving Sands, Kings

Council-Part XII

MISCELLANEOUS CONVENTIONS, MEDICAL LICENSURE, NURSING WOMAN'S AUXILIARY, OFFICE ADMINISTRA TION AND POLICIES, ETHICS, MEMORIALS

Joseph A. Geis, Chairman Essex Burrill B Crohn, New York John J Gainey, Kings J Mott Crumb Chenango Moses A. Stivers Orange

Miscellaneous Business A Frederick Williams, Chairman, Bronx John Dugan Orleans John F Kelley Onelda Richard P Doody, Rensselaer Joseph Tenopyr, Kinga Muscellaneous Business B William B Rawls Chairman, New York Joseph H. Cornell, Schenectady Morris Maslon Warren Thomas M Brennan Kings J Lewis Amster, Bronx

Résumé of Instructions of the 1947 House of Delegates and Actions Thereon of the Council, Board of Trustees, and Officers

Legislation Regarding Partnerships and Group Practice (Section 72) -As a result of report of the Planning Committee for Medical Policies, an au thorization from the House of Delegates to the Council to have legislation drafted regarding partnerships and group practice was referred by the Council to the Committee on Legislation At this whole sub-ject a still being studied by the Planning Committee for Medical Policies, the Committee on Legislation has not yet drafted proposed legislation for submiseron to the Council. See below (Section 113

Contract with Kings County Medical Society (Section 94) —The House of Delegates referred to the Council, in conjunction with the Comitia Mi-nora of the Medical Society of the County of Kings, the proposal to modify, continue or terminate a con-tract relating to book reviews for the New YORK STATE JOURNAL OF MEDICINE, medical journal exchanges, and other matters. The Council referred thus to legal counsel of the two societies for preluminary report, subsequently to be taken up by a joint committee of the Council and of the Comitia Minora of the Lings County Society In reply to a letter from Messra Martin and Clearwater Counsel of the Medical Society of the State of New York on February 6, 1948, Dr. A. W. Martin Marino, president of the Medical Society of the County of Kings wrote as follows

Mesers, Martin and Clearwater 30 Broad Street New York 4, New York

Gentlemen:
You letter of Jennary 21, 1948, addressed to our Counsel Mr. Edmand. A. Whalen, was considered at a meeting of the Transtess on Wednesday of this week.
I do not think that it is necessary to discuss at length the original agreement of 1900 between the State Medical Booley and our Booley and the slight modification of the same in 1914. The Trustess examined into all the records in our possession concerning the seld agreement and the operations thereunder for the past forty years. They are confident that they are the self agreement and the operations thereunder for the past forty years. They are confident situated the state of the past forty years. They are confident that they desire to call they over attention the all-important fact that at the time the original agreement was entered into, our Society discontinued the publication of the Broeklys Medical Jennal. Jennal of the State Boolety desire to have a mutual termination or modification of the original agreement, then it would be incumbent on the State Boolety to establish a Journal to be known as the Academy of Medicase of Breeklyn, whereby our Boolety would have all the advantages which it had originally when it published the Breeklyn Medical Jennal.

The Trustees feel that it is worthy of note that, after the probation period of five years, from 1905 to 1911 the State Boolety readment of the original agreement.

Licensing of X Ray Departments as Laboratories (Section 98) —The House instructed that Counsel should 'proceed legally to test the validity of an amendment to the Workmen's Compensation Law in relation to claums for services in connection with x ray examination diagnosis or treatment of claim ants by a licensed laboratory or bureau of a voluntary hospital. Messrs Martin and Clearwater have reported to the Council that no case has so far prosented itself which would make a proper basis for testing this part of the law

Employment of Salaried Radiologists by Hos pitals (Section 99)—The House of Delegates' reso-lution "that the Counsel of the Medical Society of the State of New York take legal steps to secure an interpretation of the statutes relating to the permissible financial relationship between hospitals and radiologists, as the result of the Reference Com-mittee report, was referred to the Council. After consideration by Council and the Legislative Com mittee, it was reported to the Council that success in securing such an interpretation would be almost impossible, and would probably entail considerable waste of time and money

X Ray Diagnosis (Section 101) -As a result of instructions from the House, the Legislative Com mittee sponsored a bill (Senate Introductory 1248
Fino Assembly Introductory 2368 Clancy) to
amend the Education Law The bill had not been acted upon by the Legislature at the time of this re-port (March 1 1948)

Group Practice (Section 113) -The House requested the Council to furnish in as much detail as possible the partnership and group practice regulations, financial agreements, and permissible par ticipation with laymen under which the members of organized medicine may practice their profession."
This was referred by the Council to the Planning Committee with the Committee on Ethics, and whatever other groups these Committees deemed ad visable The Planning Committee considered this resolution at longth on December 10 1947 This matter is still under consideration by the aforesaid Committees, and also by the Bureau of Economic Research of the American Medical Association.

Distribution of Medical Care (Section 114) -The supplying of information regarding locations for prospective practitioners, was referred by the Council to the Publication Committee This Committee has taken cognizance of this matter, and also of the many instances when prospective practituders, par ticularly general practitioners, have received help and information from the Secretary of the Society

The Joint Committee has not yet met.

Podiatry (Section 116) —Efforts of the Podiatry Society of the State of New York to enlarge the legal scope of the definition of podiatry were referred by the Council to a Subcommittee of the Legislative Committee (See Annual Report of Legislative Committee)

Several meetings were held with representatives of the Podiatry Society of the State of New York The proposed bill was carefully studied, and on recommendation of the Committee, the Council voted

not to oppose it

Training of Medical Technicians (Section 117) — The above Subcommittee received, from the Council, the House resolution and Reference Committee report regarding training of medical technicians. As a result of the interest of the Public Relations Committee of the New York Academy of Medicine, a joint committee of that body and the Medical Society of the State of New York has undertaken a complete study of this subject. The study is in progress, and has not yet been reported upon

Business Survey (Section 123) — (See Annual Report of the Committee on Office Administration and Policies) This Committee has conducted a study of the management and administration of the affairs of the Society, and has instituted a number of re-

forms and improvements

War Memorial (Section 123)—The House of Delegates referred this subject to the Council and Trustees for further study The Subcommittee of two trustees and two councilors, under the chairmanship of Dr James F Rooney, has studied and explored the establishment of a memorial to members of the Society who lost their lives in their country's service during World War II Considerable factual data have been added to material collected in two previous years (See report of War Memorial Committee)

Workmen's Compensation Board Medical Practice Committee (Section 124)—As instructed by the House, the Legislative Committee sponsored Senate Introductory Bill 2478 (Fino), Assembly Introductory Bill 1575 (Hanniford) in the 1948 New York State Legislature At the writing of this résumé, these bills are in committee On account of oppo-

sition to them by the New York State Department of Labor, it is deemed unlikely that they will pass

Relationships Between Hospitals and Specialists of Laboratory Medicine (Section 127) —The Council, having received this matter from the House of Delegates, referred it to both the Joint Committee of the Hospital Association of New York and the Medical Society of the State of New York, and to the Committee on Economics of the Medical Society of the State of New York After unavoidable delay this matter was considered under the guidance of the Committee on Economics on March 3, 1948 It was agreed that preparation of a bill for the 1949 New York State Legislature will be undertaken The object will be to define the relationships of medical specialists with hospitals and such institutions

American Medical Association Resolutions—As instructed by our House of Delegates, resolutions were introduced at the 1947 Annual Meeting of the American Medical Association House of Delegates.

The resolution regarding group practice, introduced by Dr J Stanley Kenney, was accepted in principle, and referred to the proper Council of the

American Medical Association

The resolution regarding hospital specialty boards was introduced by Dr John J Masterson It was considered by the Reference Committee, with other similar resolutions The House of Delegates took sympathetic action

Dr James R Reuling introduced a resolution regarding teaching medical economics in medical schools. On recommendation of the Reference Committee it was referred to the appropriate Board. The resolution regarding nurses, introduced by Dr Walter W Mott, was passed by the House.

The resolution regarding the American Medical Association News Releases, which Dr Harry Aranon

introduced, was defeated

The resolution about Veterans Administration home town care of service-connected disabilities re-

ceived favorable vote

The complete minutes of both the Annual and Interim Sessions of the House of Delegates of the American Medical Association have been published in the Journal of the American Medical Association

Proposed Amendments to the Constitution and Bylaws

In accordance with Article XIII of the Constitution and Bylaws, the following proposed amendments are published for the information of the House of Delegates and will be considered at its next meeting

Proposed Amendment to Article VI of the Constitution

Introduced by Dr Louis H Bauer, President Article VI of the Constitution shall be amended to to read as follows

"The Board of Trustees shall consist of nine members elected by the House of Delegates in accordance with the Bylaws The President, the Secretary, and the Treasurer shall sit with the Board of Trustees with voice but without vote"

Proposed Amendment to Chapter III, Section 3 of the Bylaws

Introduced by Dr Louis H Bauer, President Chapter III, Section 3 of the Bylaws shall be amended to read as follows

Dr James F Rooney, Albany, gave note of General Amendments to the Bylaws

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THE Technical Exhibits at the Annual Meeting at the Hotel Pennsylvania, New York City, May 18 to 21, will feature much that is new for the physician. A glance at the following paragraphs will give a resume of new and improved products and services which will be on display at the Technical Exhibits.

Abbott Laboratories, North Chicago (Booth 42) cordially invites you to view their exhibit specially prepared for this meeting and featuring products in the antibiotic, anticonvulsant ancesthetic allergenic sulfomanide hematinic, vitamin antiseptic, and other fields 'Our discussion and questions regarding newer developments will be welcomed heartily by the professional service representatives in at tendance.

The Alkalel Company Taunton, Massachusetts (Booth 23) will feature Alkalel, the balanced alka

line saline solution for the treatment of mucous membranes and irritated tissues. It is bland nontoxic and effective, and has been a favorite since 1896. We are also showing Irrigol, a powder which in solution makes an aseptic, slightly astringent vagnal douche. It is widely used also for colonic irrigations and as an effective rectal enema.

Ames Company Inc., Elkhart Indiana (Booths 120 and 121) Representatives will be glad to discuss Decholin, the standard hydrochokeretic agent for the treatment of biliary tract diseases They will be

demonstrating Clinitest and Hematest, simplified tests for the detection of urine sugar and occult blood

The Armour Laboratories, Chicago (Booths 82 and 83), invite members of the Medical Society of the State of New York to visit the Armour display If you have not received your copy of the Armour Atlas of Hematology, Function and Malfunction of the Biliary System, or The Thyroid Gland and Clinical Application of Medicinal Thyroid, copies may be obtained at the Armour display

Associated Concentrates, Inc., Elmhurst, New York (Booth 25), will exhibit various preparations used in the treatment of diseases related to faulty lipid metabolism such as psoriasis, hypercholesterolemia, and poor absorption of vitamin A A new high protein, high vitamin food preparation will be shown also Samples and literature will be distributed

Ayerst, McKenna & Harrison Ltd., New York (Booth 40) Premarin is a potent preparation of naturally occurring, water-soluble equine conjugated estrogens containing sodium estrone sulfate as one of its estrogens Premarin combines a high degree of potency with convenience of administration and is well tolerated by the patient — It is supplied with the approval of the Research Institute of Endocrinology, McGill University, and is accepted by the Council of Pharmacy and Chemistry of the American Medical Association

The Beech-Nut Packing Company, New York (Booth 87), whose baby food advertising, as well as high standards of baby food production, have been accepted by the Council of Foods and Nutrition of the American Medical Association, will feature its thirty-six varieties of strained and jumor foods

The Best Foods, Inc, New York (Booth 5), is exhibiting Nucoa, the wholesome, nutritious, vegetable margarine which contains 15,000 units of vitamin A to the pound, Also on exhibit will be the famous Best Foods—Hellmann's Real Mayonnaise and other Best Foods' products Miss Elsie Stark, director of consumer education, will be in charge of the booth and will welcome questions about the products

Bilhuber-Knoll Corp, Orange, New Jersey (Booth 81) For information on the latest developments of the medicinal chemicals of Bilhuber-Knoll Corporation, visit their booth. Your discussions will be welcomed on Denethyl, their new vasopressor, Octin, antispasmodic, Metrazol, analeptic and antianoxiant, Theocalcin, diuretic and myocardial stimulant, and Dilaudid, analgesic and cough sedative. These and their other dependable prescription chemicals are prescribed alone or in combinations with other drugs as the individual patient may require.

Ernst Bischoff Company, Inc, Ivoryton, Connecticut (Booth 28), cordially mvites you to visit their display Professional service representatives, Mr Lawrence Lesser and Mr Julian L Stratton, will be on hand and will welcome your questions concerning the use of Bischoff products in your practice

J Bishop & Company Platinum Works, Medical Products Division, Malvern, Pennsylvania (Booth 8), is exhibiting the complete Bishop line of Blue Label and Albalon hypodermic needles, syringes, and clinical thermometers S V Whitaker, Thomas Nichols, and J M Moran, Bishop representatives in

attendance, cordially invite all Convention guests to visit the Bishop exhibit



The Blakiston Company, Philadelphia, Pennsylvania (Booth 79), has prepared an attractive exhibit of new and standard books of interest to physicians in every practical field of modern medicine New volumes are listed in the Recent Advances Series, a new History of Medicine arranged for the convenience

of tracing each specialty through to its origin, new books on laboratory technic, clinical chemistry, hematology, parasitology, biochemistry, etc, are some of the interesting new books on display at the Blakiston booth



The Borden Company, New York (Booth 108), invites your attention to Gerilac, a vitaminfortified powdered milk for well-rounded nutrition in convalescence, pre- and postoperative diets, genatrics, pregnancy and lactation, and soft and liquid diets Likewise exhibited will be our long-established products

diets Likewise exhibited will be our long-established products for infant feeding Biolac, Dryco, Mull-Soy, Merrell-Soule Special Milks, general purpose Klim, and Beta Lactose

Brewer and Company, Incorporated, Worcester, Massachusetts (Booths 77 and 78) This exhibit consists of specialties centering around Theosodate, the original enteric-coated tablets of theobromine sodium acetate, and Luasmin, combination of theophylline sodium acetate, Phenobarbital and Ephedrine for the treatment of asthma Brewer capsules and ampules, other specialties including Sodium (sodium succinate-Brewer) and standard pharmaceuticals manufactured by Brewer and Company, Inc., a complete line of vitamin preparations for internal use and injections, and Gel-Ets, the newest mode in oral vitamins therapy, also are featured

Bristol Laboratories, Incorporated, New York (Booth 96) This exhibit at the 1948 meeting of the Medical Society of the State of New York will be devoted to the display of antibiotics and pharmaceutical products Qualified representatives will be on hand to assist the medical profession with any inquiries Literature describing Bristol products will be available

Burroughs Wellcome & Company (U S.A), Inc., Tuckahoe, New York (Booth 58) Among significant products featured will be Wellcome Globin Insulin, which provides an action timed to be more suitable for the average diabetic, Tabloid Empirin Compound with Codeine Phosphate gr 1, No 4, for relief of severe pain, Nutragest, the palatable dietary compound containing predigested proteins (amino acids and polypeptides), carbohydrates, and Methedrine, a recent sympathomimetic drug of wide therapeutic application

Cambridge Instrument Company, Inc., New York (Booths 126 and 127), will exhibit diagnostic instruments. Among these will be the well-known Cambridge Simpli-Trol portable model electrocardiograph and electrocardiograph-stethograph with pulse recorder, the new Cambridge electrokymograph for recording heart border motion, and

the Cambridge plethysmograph, a new calibrated instrument which makes quantitative and reproducible records

Camel Cigarettes, New York (Booths 10 and 11) will present a dramatic full color review of their recent medical research on smoking, as well as the details of the nationwide survey showing that 'More Doctors Smoke Camels Than Any Other Cigarette Another panel will illustrate the absorption of nicotine in the respiratory tract. Representatives will be present.

Cameron Heartometer Company, Chicago and New 1 ork (Booth 35) See the improved Heartometer ascientific precision instrument for recording accurately systolic and diastolic blood pressures, also furnishing a permanent graphic record of the pulse rate, disturbances of the rhythm, myocardial response the action of the valves, as well as peripheral vascular circulation. The Heartometer clearly reveals heart disturbances in both early and advanced stages and is of great value in checking the progress of medication and treatments.

Cameron Surgical Specialty Company Now York and Chicago (Booth 32) Cameron instruments are known the world over They represent the very finest in precision mechanical skill. The new items shown are the coated-lensed Omniangle (pro-grade-retrograde) gastroscope, the new stainless steel boilable bronchoscopic outfit with telescopic vision, and four sizes of radio knyes for office and hespital

S. H. Camp and Company, Jackson Michigan (Booth 75) A series of illuminated transparencies depicting anatomical conditions before and after application of Camp Anatomical Supports will be displayed Experts in attendance will answer questions pertaining to the scientific application of Anatomical Supports and advise regarding the availability of them in authorized service departments throughout the country

Canadian Radium & Uranium Corporation, New York (Booth 105) American-mined and American refined radium now available to the medical profession in any form and any type of container Old radium exchanged for new A complete line of radium instruments accessories, and protective equipment. See our new type radium D applicator for treatment of ophthalmalogic conditions—a revolutionary advance in radiation-therapy For fur ther details visit our booth

Carnation Company Los Angeles California (Booth 55) invites you to visit their booth where you will see an attractive display on Carnation Evaporated Milk—the milk every doctor knows. Some valuable information on the use of this milk for infant feedings child feeding, and general det will be presented and the method by which Carnation is fortifed genorously with pure crystalline Vitamin D—400 U.S.P. units per reconstituted quart—will be explained Interesting literature will be available for distribution.

Chatham Pharmaceuticals, Inc., Newark New Jersey (Booth 124) extends an invitation to all physicians to visit their booth. Samples, literature, and information will be available on Chatham a new anesthetic bacteriostatic fungistatic and healing Ultracain Olutment Information and literature will also be available on Koagamin Chatham's parenteral solution for increasing blood coagula billity Ciba Pharmaceutical Products, Inc., Summit New Jersey (Booth 52) invites you to visit their exhibit for latest information on steroid sex hormones. We will feature economical oral hormone therapy with Metandren Linguets the most effective oral androgen Lutocylol Linguets, the most effective oral progestogen and Ethinyl Estradiol the most potent oral estrogen. Representatives in attentiance will be glad to answer any questions that you may have concerning these and other Ciba products

The Coca-Cola Company, Atlanta Georgia (Booth 117) Ice-cold Coca-Cola will be served to the delegates with the compliments of the Coca-Cola Company through the cooperation of the Coca-Cola Bottling Company of New York, Inc

Crookes Laboratories, New York (Booth 18) On display at their exhibit will be their new fungicide Decupryl, combining copper undeoylenate with a watting agent in a fat-solvent, low-surface-tension base for times capitis and dermatophytosis, Tropasil, a new antispasmodle-antacid preparation, togother with Collo-Bul Cream, Enso-Cal and other well-known Crookes specialties

Davies, Rose & Company, Limited, Boston, Massachusetts (Booth 20) The current Quindine Sulfate situation, a perplexing problem during the past few years, will be explained by our representatives Messrs II V Orne and R. J Bannin. Our Tablets of Quindine Sulfate are and always have been, alkaloidally standardired, giving the physician assurance of uniformity in desage

The Denver Chemical Manufacturing Company Inc., New York (Booth 37) Galatest for the instantaneous determination of urine sugar, and Acctone Test (Denco) for the detection of acctone in urine will be exhibited You are cordially invited to visit our booth for demonstration of these spot tests for sugar and acctone Galatest and Acctone Test (Denco) offer advantages of accuracy simplicity and economy in routine urinalysis

Doak Company, Incorporated, Cleveland Ohio (Booth 14) Colloids of bismuth, calcium loidness and iron for parenteral administration in the treat ment of arthritis, syphilis calcium and iodine deciency Dermatological preparations for treatment of various akin manifestations.

The Doho Chemical Corporation, New York (Booths 101 and 102) The makers of Auralgan are featuring at this meeting their new sulfa preparation Otosmosan, indicated in the treatment and control of chronic suppurative cars. Also Mallon Division of Doho is introducing our new topical ancethesia, Rectalgan for rollef of pain and itching in hemorrholds and pruritus. This new therapy enjoys many advantages over the outmoded rectal suppositories and ointments. Our representatives will be happy to explain in detail the workings of these medications.

Dome Chemicals, Incorporated, New York (Booth 132) The House of Dome is the maker of the original patented modernized Burow's Solution in tablet powder, and olutinent forms. These Simplified Burow's Solution products are sold under the trademark Domeboro. The House of Dome also manufactures the rigidity standardized whole crude coal far pastes known as Daxalan and Daxalan Pediatrie.

The Drug Products Company, Inc., Passale New Jersey (Booth 9) Naotin—an effective aid in the treatment of migraine, idiopathic headache, and headache resulting from spinal tap—will feature our exhibit. There will also be displayed My opone and other therapeutic agents of interest to physicians. We will be pleased to have you call at our booth.

Durex Products, Incorporated, New York (Booth 6) Their exhibit includes a contraceptive jelly and cream, Lactikol Jelly and Lactikol Creme, accepted by the Council on Pharmacy, Durex Diaphragms, the Lactikol Diaphragm Set, several types of Diaphragm Inserters, and the Durex Sponge Rubber Model. Also shown are applicators for jelly and cream, including both the ordinary Plunger Applicator and the Aletri-Dose Applicator, which is a new syringe type for measured dosages, adjustable from 5 cc to 8 cc Duraflex Supporting Rings, a folding type similar to the Smith-Hodge hard rubber ring and much easier to insert, also will be shown

The Eaton Laboratories, Inc., Norwich, New York (Booth 21), will exhibit several pharmaceutical preparations of interest to the medical profession Furacin Soluble Dressing, containing a new chemotherapeutic agent, Furacin (brand of nitrofurazone), will be exhibited. This compound is a new anti-bacterial agent recently accepted in New and Nonofficial Remedies. Furacin solution, a new vehicle for Furacin, will also be exhibited. This new liquid vehicle for Furacin has been compounded at the request of many clinicians for use in conditions where the soluble dressing is inconvenient or contraindicated. Our representatives will be pleased to discuss these products with all who register at the Eaton booth. The latest professional literature and samples will be available.

Endo Products, Incorporated, Richmond Hill, New York (Booth 74), will feature Vifort, a new type of water-dispersible polyvitamin-drop, and Mesopin, a selective gastrointestinal antispasmodic Climcal work indicates that the aqueous form of vitamin A, as found in Vifort, is more readily and more completely utilized than vitamin A in oil solution Mesopin is a specialized antispasmodic whose action is predominantly directed toward the gastrointestinal tract. Its selective action permits more direct management of hyperactivity and spasticity without causing the undesirable and uncontrollable effects of atropine, belladonna, or related antispasmodics



Fellows Medical Manufacturing Co, Inc, New York (Booth 33), invites you to stop at their booth where they will display the latest products developed in their laboratories ArBeC

Suppositories for prompt relief and rest in asthmatic conditions, Erqua Tablets (enteric coated), sodium salicylate and menadione for safe salicylate therapy, Fello-Sed, Fellows Sedative Elixir, Ionlex, ferrous gluconate, liver, and B-complex

C B Fleet Company, Inc., Lynchburg, Virginia (Booth 2), cordially invites you to visit their booth Increasingly, during the past fifty years, to the medical profession sodium phosphate has come to mean Phospho-Soda (Fleet), the pure, stable, aqueous concentrate of the two USP sodium phosphates

General Electric X-Ray Corporation, Chicago (Booth 57) Factual discussions with members of our sales

and service organization during the state meeting will aid you in your future apparatus planning. If you are thinking about new and improved x-ray or electromedical apparatus, our layout engineers can help you with detailed plans and specifications Stop in and avail yourself of our wide experience and know-how.

Otis E Glidden & Company, Inc., Evanston, Illinois (Booth 123) Our detrulmen are eager to tell you about ZymenpL, an emulsion with Brewers' Yeast, for effective bowcl management without irritant, habit-forming drugs, dehydrating purgatives, or bulking agents Teaspoonful dosage assures a minimum liquid petrolatum intake not likely to interfere with digestive process s or fat-soluble absorption, and avoids leakage ZymenoL and descriptive literature on request

Goodman-Kleiner Company, Inc, New York (Booth 22) Physicians treating marital infertility are invited to witness actual demonstrations of two new portable instruments for use in the diagnosis and treatment of female sterility—the Weisman Gynogauge and Gynograph Employing a radical new, self-retaining, adjustable canula, the physician, without need of assistants, can now perform CO insufflation or hysterosalpingography with safety and scientific accuracy

Grant Chemical Company, Inc, New York (Booth 113) The representatives of this company, distributors of specialties for disturbances of the heart and blood vessels, will be on hand to answer any questions concerning their products. Featured at the exhibit will be their product, Diurbital, for hypertension. This product acts promptly to effect a steady, gradual descent in the blood pressure without the hazards of abrupt drops. Another product to be featured will be Procardium, an effective cardiac and basomotor stimulant, indicated for such conditions as heart failure, myocardial insufficiency, senile myocarditis, chronic passive congestion, and weakness of heart musculature

Grune & Stratton, Inc., New York (Booth 47) Among their important new books are Berson, Atlas of Plastic Surgery, with more than 1,200 illustrations, Daley & Miller, Progress in Clinical Medicine, Hill & Dameshek, The Rh Factor, Bellak, Dementia Praccox, Wolberg, Medical Hypnosis, in 2 volumes—In the periodical field Grune & Stratton is now the sole agent for the thirteen journals published by the British Medical Association

Harold Supply Corporation, New York (Booth 3)
Agents for Hamilton Furniture-Ritter Equipment
Continental X-Ray-Birtcher FCC Approved Short
Wave will display surgical specialties In charge of
the booth will be S Mehlinger and J Shnitzer

The Harrower Laboratory, Incorporated, Glendale, California (Booth 110) The exhibit presents gastroscopic and acidity control studies relative to Mucotin, a new physiologic treatment for peptic ulcer The exhibit is divided into three parts 1. A case history report with gastroscopic illustrations 2. Gastric acidity control, as achieved by various antacids. 3. Gastroscopic illustrations of Mucotin's ulcer coating action.

H J Heinz Company, Pittsburgh, Pennsylvania (Booth 62), cordially invites you to visit its booth where you will see an attractive display presenting

interesting information on the uses of Heinz Strained and Junier Foods. The twelfth edition of the popular Nutritional Chart is available upon request. When you visit our exhibit, register for it

Hoffmann-La Roche, Inc., Nutley New Jersey (Booth 65) invites members of the society to visit their booth where members of the representative staff will be present to discuss such new products as Syrup Sedulon, a sedative cough preparation, Thephonn an antibustamine compound, Rayopake, a contrast medium, and other products of in terest to physicians

Holland Rantos Company Inc. New York and Los Angeles Californa (Booth 36) Koromex Jelly and Koromex Cream will be featured at their booth. You may recall it was the Holland Rantos Company, Inc. that pioneered the introduction of modern contraceptive technic—so frequently referred to as the Koromex Method The medical background and clinical use of Koromex Jelly dates back to 1925 Medical service representatives will be on hand to discuss with interested physicians the latest data on Koromex Jelly and Creum

Interchemical Corporation, The Blochemical Division, Union New Jersey (Booth 30), will display its Lyophilized intravenous amino-acid proparation Glutamic and aspartic acids have been partially removed to assure relative freedom from nauses and vomiting A cordial invitation is extended to vistors to observe soveral important steps in the manufacture of this product and to discuss its ments with the representatives.

International Vitamin Division, Ives-Cameron Company Inc., New York (Booths 97 and 98) New and important vitamin specialities will be the featured items in the IVC exhibit. Included will be Licovite Capsules, a potent hematopetic containing folic acid in addition to liver, iron and the B vitamins Evramin Granules, a new advance in calcium therapy. Dee Flurea Wafers a scientifically balanced anticaries fluorine preparation and Provite B a superior B complex product containing choline and inositol. IVC's group of Council-accepted decage forms will also be displayed. Clinical manifestations of avitaminoses will be illustrated with technicolor photographs, designed to serve as diagnostic aids. Their medical director and trained medical representatives will be on hand to welcome members of the profession and answer inquires.

Kalak Water Company of New York, New York (Booth 129) Members and guests are cortially invited to visit our booth. We will have in attend ance a representative qualified to discuss body fluids Fluids are important to the well being of man. Kalak is valuable to replace salts normally present in the body fluids and to alk salts normally

The Kelley Koett Manufacturing Company, Coving ton Kentucky (Booth 39) has on display the Keleket KXP 100 combination. This unit provides a complete diagnostic x ray unit for the general practitioner clinic and small hospital. This compact unit combines both radiographic and fluorescopic facilities and takes up limited space.

Kellogg Company, Battle Creek Michigan (Booth 13) Rellogg's coreals have an important place in restricted and normal diets because they contain valuable nutrients found in whole grains. All-Bran is one of the best sources of iron Corn Flakes and

Ruce Krispies are indicated in bland and low residue diets. Diet manuals and pads of special diets are available. Mrs Winefred B Loggans is in charge of the display

Kidde Manufacturing Company, Inc., Bloomfield, New Jersoy (Booth 128) The new Kidde-Uter Taubal Insuffiator with Gasometer pressure control Completely safe, gravity pressure control simple operation single control Requires only small cartridge of carbon-doxido gas Provides diagnostic and therapeutic use of carbon-doxide gas or opeque oil Kymographic record of patency test. Also on display the Kidde Dry Ioe Apparatus used in treatment of superficial skin lesions. This apparatus is becoming increasingly popular because of its simplicity and the superior coxmetic results obtained

H. W Kinney & Sons, Inc., Columbus, Indiana (Booth A) Physicans of the 142nd Annual Meeting of the Medical Society of the State of New 1 ork are cordially invited to visit the Kinney exhibit featuring Cartose and Kinney's yeast preparations. In attendance will be Messrs Frederic T C Brewer and Vadim P Medwedeff

Lakeside Leboratories, Inc., Milwaukee, Wisconsm. (Booth 63), will feature the modern management of cardiac decompensation in general practice. The new schedules and technics of medical treatment in this condition will be the point of interest at the Lakeside exhibit. Representatives will be prepared to discuss these problems and will be equipped with reprints of clinical publications and other materials bearing on this rapidly changing subject. A new form of dose-weight chart, facilitating the record of the cardiac patient's progress will be available to physicians.

Lanteen Medical Laboratories Inc. Chicago (Booth 125) extends an invitation to virit their exhibit Featured will be Procarmin and also their well-known line of gynecic specialties

Lea and Febiger, Philadelphia, Pennsylvania (Booth 17) This exhibit is of particular interest because of such outstanding new books and new editions as Frohman, Brief Psychotherapy Ormsby and Mont genery, Diseases of the Skin Themes and Haley Clinical Tericology Goldberger Unipolar Lead Electrocardiography Stimson Common Contagious Diseases Burch and Reasor Primer of Cardiology, and many others Our representative will be glad to help you with your individual book problems.

Lederle Laboratories Division, American Cyanamid Company Now York (Booth 16) The Lederle exhibit will feature purogenated diphthera, totanus, and diphthera totanus toxonds new highly refined antigens characterized by lessend reactivity and antigenic in lower doses, Folvite brand folic acid a synthetic product useful in certain types of macrocytic anemias, and Cardiolipin a stable non-nitrogenous phospholipid from beef beart used in tests for syphilis.

Ruth and Florence Lee, B.S., M.A., Medical Illustrators, New York (Booth E) an exhibition of surgical, pathologic, and anatomic drawings These and other drawings have been used by prominent physicians and surgeons in the fields of abdominal surgery anesthosology gynecology and obstetrics, neurology and neurosurgery ophthalmology, oral surgery otolaryngology, orthopedic surgery plastic surgery and urology We were em-

ployed for the purpose of illustrating textbooks, articles in medical journals, lectures, and exhibitions

The Liebel-Flarsheim Company, Cincinnati, Ohio (Booth 50), cordially invites you to stop at their booth for examination and demonstration of their SW-227 FCC-Approved Diathermy Unit and Bovie electrosurgical apparatus Capable representatives will be on hand at all times to answer your questions about physical therapy and electrosurgical apparatus We hope you will stop by so that we may become acquainted

Eli Lilly and Company, Indianapolis, Indiana (Booth 69) The Lilly exhibit for 1948 features a presentation on Dolophine Hydrochloride (Methadon Hydrochloride, Lilly) You will be interested in the comparison of postoperative relief of pain with Dolophine Hydrochloride, 10 mg, and Morphine, 15 mg Many other Lilly products will be on display Attending Lilly medical service representatives will and visiting physicians in every way possible

J B Lippincott Company, Philadelphia, Pennsylvania (Booth 46), presents an interesting and active exhibit of professional publishing. With the "pulse of practice" centering in an advisory editorial board of active clinicians who constantly review the field, current and coming trends in medicine and surgery are known continually. On the studied recommendations of these medical leaders, Lippincott Selected Professional Books are undertaken. It is upon their knowledge, too, of the outstanding work being done in general practice, as well as the specialties, that men making a very real contribution to medical progress are chosen to author the Lippincott books.

M & R Dietetic Laboratories, Inc., Columbus, Ohio (Booth 45), will display Similac, a food for infants deprived either partially or entirely of breast milk Messrs A. A Hardy, T G Brown, and M Goldwater will appreciate the opportunity to discuss the ment and suggested application for both the normal and special feeding cases

The Maltbie Chemical Company, Newark, New Jersey (Booth 27) Selective oral therapy in hepatobiliary disease will be the main feature of the Maltbie exhibit Trained representatives will be present to explain the application of Cholan-DH and Cholanox, as well as other Maltbie specialties Special requests will receive immediate attention. All physicians and guests are cordially invited to attend

The Maltine Company, New York (Booth 131) Cellothyl, an entirely new development in bulk laxative therapy, is one of the featured products at their booth. Physicians are invited to visit their booth and obtain samples and information of this new product. Also on display are Proloid, Tedral, and Depancol. If you have not received your memorandum books for this year, ask for a set

McNeil Laboratories, Incorporated, Philadelphia, Pennsylvania (Booth 76)

Mead Johnson & Company, Evansville, Indiana (Booth 59) Amigen and Protolysate will be on display at the Mead Johnson Exhibit at your Medical Society of the State of New York meeting Mead Johnson has pioneered the amino-acid field commercially, the products have been described in more than one hundred and forty articles in the medical literature, this year they are available Trained representatives will be at the Mead Exhibit to dis-

cuss details of the new amino-acid products Shown also will be Dextri-Maltose, Pablum, Pabena, Oleum Percomorphum, and the other Mead products used in infant nutrition Protenum, a new high-protein product, and Lonalac for low-sodium diets will be displayed

Medical Film Guild, New York (Parlor C), through "Medical Films That Teach" presents a refresher course in fundamental medical problems. The films review such subjects as Parkinson's disease, major neuralgias, cervicitis, otolaryngological diseases, contagious diseases, arterial blood pressure, hypothyroidism, industrial medicine. These are available to medical institutions, including projection service, at no charge, through grants for postgraduate instruction.

Merck & Company, Inc, Rahway, New Jersey (Booth 86), presents Neo-Antergan, a new effective antihistaminic agent for symptomatic relief in the oral treatment of certain allergic states, including hay fever, vasomotor rhinitis, urticaria, angioneurotic edema, and allergic drug reactions including those due to penicillin and streptomycin Register for a complimentary professional sample of Neo-Antergan

The Wm S Merrell Company, Cincinnati, Ohio (Booth 53) Infazyme, the new pleasant-tasting nutrient, especially designed for the "sickly" child, will be featured at the Merrell booth Infazyme combines the whole vitamin B complex with readily available iron and supplementary amounts of the essential amino-acids in a rich fruity-flavored liquid concentrate

Philip Morris & Company, New York (Booth 116), will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss research on this subject and problems on the physiologic effect of smoking

The C V Mosby Company, St Louis, Missouri (Booth 41) New books and new editions to be displayed at their booth will include Pottenger, Tuberculosis, Crosse, Operative Gynecology, Ilgenfritz, Pre-operative and Post-operative Care, Black-Vaughan, Practice of Allergy, Dunbar, Synopsis of Psychosomatic Diagnosis and Treatment, Watson, Hernia, Johnstone, Occupational Medicine and Industrial Hygiene, Gradwohl, Clinical Laboratory Methods and Diagnosis, Goar, Synopsis of Ophthalmology, Shands, Handbook of Orthopedic Surgery, Muncie, Psychobiology and Psychiatry Your examination of these, or of many other texts to be shown, is cordially invited

The National Dairy Council, Chicago, (Booth 26), cordially invites you to visit an exhibit of health education material at their booth. The background exhibit breaks down the nutrients in ice cream, showing clearly what this dairy food contains that contributes to daily food needs. Booklets and posters, giving timely and authentic nutrition information, may be requested.

Nestle's Milk Products, Inc., New York (Booth 70), cordially invites you to visit their exhibit where specially qualified representatives will be on hand to answer your questions on any of Nestle's milk products—already best known and most used for babies "round the world" New pieces of valuable professional literature will be available

The New York Medical Exchange, New York, (Booth 44), will have a representative, Miss Lillian Zander who will be glad to consult with you regard ing personnel for your office or your hospital. She will have the eredentials of young assistant physicians, secretaries nurses, in short—any medically trained personnel, also a list of interesting well paid comportunities. Don't nexteet to see her

Ortho Pharmaceutical Corporation, Raritan, Now Jersey (Booth 7) cordially invites you to visit their booth where their well-known group of synecio specialties, including Ortho-Gynol and Ortho-Cremo, will be exhibited Featured are Dienestrol Cream for the treatment of senile and atrophic vulvovaginitis, and Nidoxital Capsules, for the centrol of nausea and yoniting of pregnancy

Parke, Davis and Company, Dotroit, Michigan (Booth 56) Membors of our medical service staff, fully informed regarding the progress in pharma ceutical and biological research and desirous of presenting various new advancements to you will be on hand at our technical exhibit to discuss new and old products Featured will be such outstanding specialties as benadryl, vitamins, adrenalin oxycel and thrombin topical Also the most recent types of biologicals, including other therapeutic agents of chemotherapeutic interest, will be displayed We invite you to visit our exhibit while attending this meeting

Pet Milk Company, St Louis, Missouri (Booths 67 & 68) An actual working model of a milk condensing plant in miniature will be exhibited by the Pet Milk Company in their booth. This exhibit offers an opportunity to obtain information about the production of Pet Milk, its use in infant feeding and the time-saving Pet Milk services available to physicians. Miniature Pet Milk cans will be given to the physicians who visit the Pet Milk booth

Picker X Ray Corporation, New York (Booths 106 and 107), will exhibit its up-to-date radiographic and fluoroscopic equipment for use in hospitals and private offices There will also be on display accessories designed primarily to facilitate work in the x-ray department

Pitman-Moore Company, Indianapolis, Indiana (Booth 4) will feature some new advances in sulfonamide medication designed still further to reduce the danger of crystaluria, a recent imperment in the treatment of gastric hyperacidity, and other late research developments Laboratory scentists will be on hand to assist the company's New York representatives in answering technical questions and explaining recent medical salvances.

Premo Pharmaceutical Laboratories, New York (Booth 1) Graphically portrayed in this new exhibit are contemporary contributions by Premo Pharmaceutical Laboratories to the administration of penicillin—acrosol—oral and nasal Also exhibited is the Premo refinement in the application of penicillin in oil and wax. Demonstrations of Premo adaptations and methods are performed by medical services representatives. Literature is available on the late research and developments of Premo Pharmaceutical Laboratories.

The Procter & Gamble Company Cincinnati Ohio (Booth 66), offers the first four of a series of time-saving leaflet pads for doctors These are entitled Instructions for the Routine Care of Acne, In-

structions for Bathing a Patient in Bod 'Instructions for Bathing Your Baby, and The Hygiene of Pregnancy'

Professional Printing Company, New York (Booth 73) "America's Largest Printers to the Professions," cordially invites you to attend the showing of their products. This year they are celebrating their twentieth anniversary. Twonty years of continuous progress in doctors' stationery, records and supplies. The originators of the famous Histacount Bookkeeping System, Histacount record forms, doctor's Efficiency File, filing supplies, and many other executal items for a doctor's office

The Radium Emmation Corporation, New York (Booth 180), invites you to our booth, where we will exhibit a wide variety of instruments and applicators used in modern radium therapy including permanent and removable leak proof radion seeds. Our representative will be available to explain this equipment and its usage.

Rare Chemicals, Inc., Harrison, New Jersey (Booth 109) Preparations exhibited by Rare Chemicals, Inc will include Acidolate (nonlathering liquid) and Dermolate (new lathering cake) both non-uritating skin detergents, Arsenoferratose palatable homatime, Dienestrol, new low-cost estrogonic preparation with little or no side reactions. Europpin local anesthetic with prolonged analgesic action, Gitalin, digitalis preparation, Salyasl, antirheum atte analgesic, and the male hormones Testosterone Propionate Rare for parenteral use, Methyl Testosterone Rare for oral administration

L. & B Reiner, Incorporated, New York (Booth 31) Factory representatives exhibiting The Jones Motor Basai original waterless metabolism machine, featuring a self-correcting double slope tracing and no calculations. E P L. Cardiotron, the first successful direct recording electrocardiograph with numerous distinctive features. The H. G Fisher line of shockproof x ray apparatus W D Allison Co fine furniture for physicians

Rexair Division, Martin-Parry Corporation, Toledo Ohio (Booth 34) Rexair is a portable air cleaner that performs many household and hospital jobs It purifies deodorizes, and humidifies the air cleans floors, walls and furniture, scrubs floors draws in dust-laden air and sends out clean, most air Dirt is trapped in water poured down the drain. There is no bag to empty

J B Roerig and Company, Chicago (Booth 71) Attonding physicians are cordially invited to attend their exhibit. Members of the professional service department will be on hand to explain in detail the several products which will be displayed Two new products will be featured Lactons, a new protein hydrolysate, and Obron the new dicalcium phosphate iron, and vitamin capsule which will appeal to many physicians. Company representatives will welcome all inquiries and will be pleased to extend the courtesy of the professional service department to all vanitors

Sanborn Company, Cambridge, Massachusetts (Booth 15) is demonstrating its direct-writing electrocardiograph, the Viso-Cardiotte, and its latest metabolism tester the Metabulator, at our booth Complete sales and service information available

Sandoz Chemical Works, Incorporated, New York (Booth 84), are exhibiting a new anti-epileptic drug, Mesantoin (methyl-phenyl-ethyl-hydantoin), for the control or reduction in the frequency of epileptic seizures. Other new products are Dihydroergotamine Sandoz (DHE 45), the new improved non-narcotic relief for migraine (Dihydroergotamine lessens incidence of nausea and vomiting, uterotonic effect of ergotamine is practically eliminated, sympathico-inhibitory effect is enhanced), Glysennid for constipation, contains the crystalline glycosides from senna leaves, Sennosides A and B, Cedilanid, stable preparation of Lanatoside C, a crystalline glycoside from Digitalis Lannata, not present in purpurea, Ipesandrine Syrup for the relief of cough and bronchial disorders, containing the active alkaloids of Dover's Powder in pure form with ephedrine Other well known Sandoz products include Gynergen, Digilanid, Bellafoline, Bellandenal, Bellergal, Calcibronat, Scillaren, Strophosid, Calglucon, and Neo-Calglucon

Saratoga Springs Authority, Saratoga Springs, New York (Booth 88) This exhibit consists of a photographic montage designed to show facilities available to the public at the Saratoga Spa as part of the health service of New York State. The photographs were taken in and about the various buildings on the State's 1,200-acre reservation. They display the bottling and distribution of the natural mineral waters, scenic views, recreation facilities, and various treatments using natural mineral waters as given at the bath houses. These include mineral baths and packs, as well as heat cabinet, light ray, and other treatments. State-bottled geyser water will be served by an attendant throughout the meeting.

Schenley Laboratories, Incorporated, New York (Booth 38), exhibit will feature Penicillin Vaginal Suppositories, for treatment of infections in the vagina and cervix, and routine prophylactic use in obstetrics, Penicillinase, a clinical laboratory reagent, Rutaminal Tablets (rutin, aminophylline, and phenobarbital) for use in cardiovascular conditions, Titralac, a new antacid with a titration curve resembling that of milk

Schering Corporation, Bloomfield, New Jersey (Booth 93) Important new hormone and pharmaceutical preparations will be featured at the Schering booth Alicropellets Progynon is a new potent form of the female sex hormone Combisul and Combisul Liquid are the triple sulfonamide combinations which eliminate the dangers of sulfonamide renal damage New high potencies of Oreton-M, Pranone, and Progynon-B are presented Schering professional service representatives will welcome you and will be happy to answer your inquiries concerning Schering's new products as well as the older and time-tested hormones, x-ray diagnostic, chemotherapeutic, and pharmaceutical preparations

Schieffelin & Company, New York (Booth 12) Schieffelin Benzestrol, a syntheticlestrogen developed in the Research Laboratories of Schieffelin & Company, is featured for three forms of administration—oral, parenteral, and vaginal A qualified staff will be on hand to discuss the advantages of Benzestrol and the use of each form, and to answer any questions Literature will be available, and information on other Schieffelin products may be secured

Julius Schmid, Incorporated, New York (Booth 80) Why Ramses Prescription Packet #501 supplies optimum protection with simplicity in use will be shown in color Representatives will be present to answer any physician's questions concerning Ramses Gynecological Products, every one Council-Accepted Ramses Flexible Cushioned Diaphragm, Ramses Diaphragm Introducer, Ramses Vaginal Jelly, Ramses Vaginal Applicator, Ramses Fitting Rings

G D Searle & Company, Chicago (Booth 64), cordially invites you to visit the Searle booth, where our representatives will be happy to answer any questions regarding Searle Products of Research Featured will be Hydryllin, the new antihistaminic, as well as such time-proved products as Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine, and Pavatrine with phenobarbital

Sharp & Dohme, Incorporated, Philadelphia, Penn sylvania (Booth 51), extends a cordial welcome to all visitors at their booth. Items on exhibit include a new dosage form of Delvinal Sodium Vinbarbital, for the production of obstetric amnesia and analgesia, new antibiotic preparations including Tyrothricin, along with Sulfathalidine and Sulfasuxidine, intestinal bacteriostatic agents

Smith, Kline & French Laboratories, Philadelphia, Pennsylvania (Booths 91 and 92) Eskay's Oralator will be a feature at this exhibit Eskay's Oralator provides a revolutionary method of cough control Inhaled by mouth, the Oralator's anestheticanalgesic vapor (2-amino-6-methylheptane) is delivered directly to the nerve endings in the trachea and larynx, where it controls cough within a matter of seconds Safe and effective, the Oralator is indicated in those types of coughs for which codeine would ordinarily be prescribed. Unlike sedatives and narcotics, however, the Oralator produces no appreciable systemic effects. Our specially trained professional representatives will be glad to answer questions concerning the possible uses of our products in your practice.

C M Sorensen Company, Inc, New York (Booth 119) We are looking forward to greeting old friends and making new acquaintances at this years's State Medical Meeting. We are in high hopes of presenting to visitors at our booth several new items of real interest to all who are engaged in ear, nose, and throat work.

Spencer, Incorporated, New Haven, Connecticut (Booth 72), cordially invites you to visit our exhibit showing individually designed supports for abdomen, back, and breasts Among the supports featured will be the Spencerflex, an unusually comfortable and flexible support for men, especially suitable for postoperative wear The Spencer Breast Form, designed to restore normal figure lines for patients who have undergone mastectomy, will also be shown

E R. Squibb & Sons, New York (Booth 54) Streptomycin—certain clinical problems

The Stiefel Medicinal Soap Company, Inc, Preston Hollow, New York (Booth B), has been serving the medical profession throughout the world for over one hundred years. The business was founded in Europe in 1847. The American Company, operated by direct descendants (grandson and greatgrandson), has been carrying on in the western hemisphere for more than twenty years. The Stiefel Medicinal Soap Company, Inc, introduces at this time three new soap products—new and distinguished. (1)

An oil saturated toilet soap (in contradistinction to grouse extended-superintied soap) (2) Tar Shampoo (cake and liquid) made with especially prepared crude coal tar (3) Special detergent soap (Aene Aid) High detergence and no abrusives. These are in addition to many other items of medicated soaps

Tampax, Incorporated New York (Booth 29) Patients are constantly demanding authoritative in formation and up-to-date instruction in the use of the Tampax method of mensirual protection in three absorbancies Our educational consultants at our booth welcome the opportunity to discuss with you the many ligience features of this leading intravagnal tampon. You will want to see the new Tampax wender now being distributed for installation in vomen a rest mons.

The Tarbonis Company, Cleveland Ohlo (Booth 24) Tarbonis Cream—tar in a highly cosmotic form—is one of the achievements pioneered by Tarbonis It combines thempeutic efficiency superior to ordinary tar preparations with this patient-appreciated form Samples and literature are offered at the Tarbonis booth



Teca Corporation, New York (Booth 114), exhibits its latest models of low volt generators and ultra violet lamps Shown are among other models the new low volt generator CD7 featuring variable frequencies, controls for surge

and rest periods and built-in cathode-ray oscilloscope, also generator models CD6 and SP3 with original facilities and circuit divisions. The new model UV 2 ultra-violet lamp, having individual controls for corex and quartz will be demonstrated

Marvin R. Thompson, Incorporated, Stamford, Connecticut (Booth 48) A display of a series of M R.T products which enable the physician to insure optimal nutrition in his patients regardless of declar deficiencies. The importance of the practical nutritional approach and its relationship to diagnosis, prophylaxis, and therapousis is stressed as it pertains to general practice.

United Medical Service—The Doctors Plan, New York (Booth D) Nonprofit, voluntary prepayment plan created and sponsored by the seventeen county medical societies in the Greater New York Area Educational posters, photographs charts, and pamphlots relating to the growth and development of U.M.S.

US Vitamin Corporation, New York (Booth 81) Full color Illustrated brochure Pragnosing Vitamin Deficiences togother with professional samples and literature on ViSyneral, Poly B Vi-Litron Hypervitam Lipo-Heplex, Daisol Desiver Amiprote, Rutin Rutascorb Methischol Tri-Sulfanyl and others.

University of Chicago Press, Chicago (Booth 122) Distinguished for authoritative content and axcelonce of editorial work, the books of university presses claim envisible rank among nonfiction and technical publications. The Association of American University Presses has arranged a cooperative exhibit for your enjoyment at this meeting—and to give you an opportunity to purchase some of the important titles for your brary.

The Upjohn Company Kalamazoo, Michigan (Booths 94 and 95) Adrenal Cortox and Resistance the central panel of this exhibit, symbolizes that mans resistance to stress is being increased by science. The other panels show the effect on the adrenals of various stresses—infection, aversise, surgery and anoxis. The final panel shows the relative potency of adrenal cortex sterile solution and hipo-adrenal cortex sterile solution and hipo-adrenal cortex sterile solution

Van Pelt and Brown, Incorporated, Richmond, Virginia (Booth 112) Of special interest is Vifoliton, our new hematine and hemopoetic preparation containing ferrous gluconate, liver concentrate, folicated and vitamins in convenient tablet form Representatives will be in attendance at all times to answer inquiries regarding this and our other preparations such as Barbidonna, Bellaspro and Gluco-Ferrum

Varick Pharmacal Company, Inc. New York (Booths 103 and 104) The manufacturers of Dogitaline Nativelle plan an interesting and in formative exhibit on heart disease Of special in terest are the phonographically reproduced heart sounds of various valvula lesions. Physicians are cordially invited to sit and listen via individual head sots to the accurate reproductions of many atmormalities, such as auricular fibrillation, gallup rhythm, presystellic murmurs ote Enlarged full color kodachromes of many gross cardiac specimens and photomicrographs of cardiac pathology will be displayed. Literature and information on Digitaline Nativelle in the treatment of congestive heart failure auricular fibrillation and flutter will be available.

Walker Vitamin Products, Incorporated, Mount Vernon, New York (Booth 19) Therapeutic vitamin proparations, protein products, and individual amino acids will be presented at this exhibit. Also the oral and injectable combinations of vitamins and amino acids as used in the hearing studies reported in the December 1946 Archives of Olclaryngology These two preparations—Hyvanol and Amvitol—may prove to be of great value in the treatment of certain types of nerve deafness

Wallace Laboratories, Incorporated, Princeton New Jorsoy (Booth 118) Intraderm products for the treatment of common skin conditions will be exhibited. Intraderm Sulfur for nene yulgaris and Intraderm Tyrothrein for pyodermas are among the leading products of this pharmacoutical house, which also offers T.C.A.P. Fungledal Ontment for skin ringworm and athlete a foot

Wallace & Tiernan Products, Belleville New Jersey (Booth 43) welcome viating physicians at their booth In addition to their widely used prescription specialties—Axochloramid Monomestrol, and Desenex—they will display Sotraderol a new syn thetic substance for the injection treatment of varaccese veins

William R. Wamer and Company Inc., New York (Booth 40) is exhibiting two new highly effective drugs—Intracilin and Heparin/Pitkin Meastraum Intracilin is an injectable crystalline penicilin G with spinephrine in oil, which gives sustained 12 to 24-hour blood levels Heparin/Pitkin Meastraum provides prolonged anticoagulant action in thromboembolic disease obviating the need for repeated in jections Many other important Warner Drugs will be displayed.

Westinghouse Electric Corporation, New York (Booth 115), presents the "RX," an outstanding new low cost x-ray unit combining both complete radiographic and fluoroscopic facilities for either erect or prone usage Conversion of this equipment is made in a matter of seconds, and floor space is reduced to only six square feet

Westwood Pharmacal Corporation, Buffalo, New York (Booth 111) Low-salt diets without sacrificing the palatability of meals are now possible for your cardiac, hypertension, and pregnancy toxemia patients with Westsal, the salt substitute containing no salt but tasting exactly like salt. Drop in at our booth for full particulars and for our challenge that you cannot differentiate the taste of Westsal from the taste of common table salt. Westwood also exhibits the new improved single-dose disposable applicators for Westhazole Vaginal, the therapy of choice for vaginal and cervical infections.

Whirlpool Carriage, Incorporated, Westport, Connecticut (Booth 60) The Whirlpool Carriage offers partial and complete body whirlpool therapy in any type of bath tub The patient can be manipulated while receiving whirlpool therapy for every part of the body Spray therapy is also featured The carriage is a compact, portable, and well-constructed piece of home, office, and hospital equipment

White Laboratories, Incorporated, Newark, New Jersey (Booths 89 and 90) White's Dienestrol Tablets (Council-Accepted), a new orally effective synthetic estrogen, are featured Complete information and literature are available regarding the advantages of Dienestrol's high biologic activity, excellent patient-tolerance, and economy Other products of White Laboratories are on display and White's medical service representatives in attendance will be pleased to supply any further information requested

Winthrop-Stearns, Incorporated, New York (Booths 99 and 100), extends a cordial invitation to visit their booths, where representatives will be on hand to discuss the latest pharmaceutical preparations offered by this firm Featured will be Neo-Synephrine with penicillin, Demerol, powerful analgesic, spasmolytic, and sedative, Creamalin, nonalkaline, nonabsorbable antiacid, and Neocurtasal, sodium-free seasoning agent

Wyeth Incorporated, Philadelphia, Pennsylvania (Booth 85), is exhibiting two outstanding products at the annual meeting of the Medical Society—They are penicillin (calcium) in oil and wax (Romansky formula), which remains fluid and stable without heating or refrigeration, and Purodigin, crystalline digitoxin, for congestive heart failure, effective in small oral doses, completely absorbed, with minimal side effects

Plan now to visit the

TECHNICAL EXHIBITS

before and after each day's events

Ballroom Floor

Exhibits Open

Tuesday, Wednesday, Thursday--9 A M to 6 P M. Friday--9 A.M to 2 P M

WOMAN'S AUXILIARY

TO THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

ANNUAL CONVENTION

Hotel Pennsylvania, New York, May 16 to 19, 1948

THE ANNUAL CONVENTION of the Woman's Auxiliary to the Medical Society of the State of New York will be held May 16 to 19, 1948, at the Hotel Pennsylvania, New York City

All doctors' wives, whether members of a Woman's Auxiliary to a county medical society or not, are urged to register at the Registration Deak, in the Foyer of the Penn Top They are cordially invited to participate in all parts of the program

PROGRAM

7 00 P.M

Informal Supper Party-Manhattan

	Canaday, rady ro		The Popper and American
2 00 р.м.— 5 00 р.м	Registration of Delegates Alternates, Guests—Penn Top Foyer Registration for informal Supper		Room East
	Party-Monday, May 17, 7 00		Tuesday, May 18
	P.M., for Luncheon and Fashion Show—Tuesday, May 18, 12 30	9 00 A.M -	Registration, all doctors' wives-
	P.M	5 00 p.m. 9 30 a.u	Penn Top Foyer
		9 30 A.M	House of Delegates Meeting Second Half—Penn Top South
	Monday, May 17	12 30 р.м.	Luncheon and Fashion Show-Man
	Registration, all doctors' wives-	2 30 р.м.	hattan Room
5 00 P.M.	Penn Top Foyer	2 30 P.B.	House of Delegates Meeting—Penn Top South
	Party—Monday, May 17, 7 00 r.u., for Luncheon and Fashion		ropoodd
	Show-Tuesday May 18, 12 80		Wednesday, May 19
9 00 A.M	P.M Registration of Delegates	10 00 a.m.	Postconvention Meeting of Executive
12 Noon	Troping prior of Delogates		Board-Conference Room 2
10 00 A.M.	Preconvention Meeting of Executive	11 00 A.M.	Conference with County Presidents-
	Board—Penn Top South		Conference Room 2
130 г.м.	House of Delegates Meeting First	7 00 г.н.	Banquet, Medical Society of the State
	Half—Penn Top South		of New York—Penn Top

OFFICERS

Sunday, May 16

WOMEN'S MEDICAL SOCIETY OF NEW YORK STATE

ANNUAL MEETING

Hotel Pennsylvania, New York, May 16-17, 1948

THE forty-first Annual Meeting of the Women's Medical Society of New York State will be held in New York, May 16 and 17

The President's Tea, honoring Dr Helen G Walker, will be held Sunday afternoon, May 16, at the residence of Dr Leoni N Claman, 40 East 88th Street, New York City, from 4 to 7 PM

The program for Monday, May 17, is as follows

9 00 AM —Registration, Manhattan Room South,

10 00 AM—Business Meeting, Manhattan Room West, 1 00 PM—Luncheon, Manhattan Room East, 2 00 PM—Scientific Session—"Symposium Vascular Diseases," Teresa McGovern, MD, New York City, Audrie L Bobb, MD, New York City, and Margaret Stanley-Brown, MD, New York City, Morbettan Room West. City, Manhattan Room West.

Helen G Walker, M.D., President Jennie D Klein, M.D., Secretary

Officers of the Women's Medical Society

Honorary Presidents

Mary T Greene M D Helene J C Kuhlmann M D Rosalie Slaughter Morton M D

President

Helen G Walker M D 422 Sidway Building Buffalo

Vice-Presidents

Sophy Page Carlucci M D
61 Washington Ave Endicott
Ruth Ewing M D
50 East 10th St. New York City
Elizabeth Vuornos M D
12 Chestnut St. Liberty

Secretary

Jennie D Klein M D 422 Sidway Building Buffalo

Treasurer

Julia Lichtenstein M D 2 West 87th St New York City

COUNCILORS

1st Distric! Branch

Madge C L McG finness M D 51 East 87th St New York City

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Jessie G Merin M D Bolton Landing

5th District Branch

Lois L Gannett M D 67 East Church St Adams

6th District Branch

Myrtle Wilcox-Vincent, M D

134 Main St., Binghamton

7th District Branch Marion Young Sten M D 99 Edmore St Rochester

8th District Branch

Rose M Lenahan M D 605 Lafayette Ave Buffalo

Honorary Councilors

Helene J C Kuhlmann M D Helene J C Kuhlmann M D
Emily Dunning Barnniger M D
Lois L Gannett M D
Esther Parker M D
Mary Dunning Rose M D
Ethel Doty Brown M D
Rosalie Slaughter Morton M D
Anna H Voorhis M D
Marion S Morse M D
Mary J Kazmierezak M D
Clara H Pierce, M D
Elise S L Experance, M D
Madge C L McGuinness M D
Marguerite P McCarthy M D
Theresa Scanlan M D Theresa Scanlan M D

Honorary Members

Judge Dorothy Kenyon Catherine Macfarlane M D Philadelphia, Pa.

CHAIRMEN OF COMMITTEES

Scientific Program

Leonora Andersen M D 140 East 54th St New York City

Legislative

Lois J Plummer M D 131 Linwood Ave , Buffalo

Medical Education

Mary T Greene M D Samtarium Castile

Public Health

Sophie Rabinoff M D 166 East 96th St New York City

Public Relations

Leoni Claman M D 40 East 88th St , New York City

Membership

Mary A Jennings M D 349 East 49th St , New York City

Mary J Kazmierczak M D 957 Sycamore St Buffalo

Medical Economics

Theresa Scanlan M D 133 East 58th St New York City

Arrangements

Adelaide Romaine, M D
35 West 9th St New York City
Helen I Heiman M D
15 West 81st St New York City

Scientific Articles

ONE-STAGE SUPRAPUBIC PROSTATECTOMY WITH PRIMARY CLOSURE OF THE BLADDER

W C EIKNER, M D, Clifton Springs, New York (From the Clifton Springs Sanitarium and Clinic)

THE results of surgical treatment of benign hypertrophy of the prostate are now so gratifying that patients suffering from such a con dition need have no fears as to the outcome of the These good results have come about during the past forty years by the efforts of urologists to improve their skill not only in the per formance of the operation but also in the particu lar care of the patient before and after operation It is not the purpose of this paper to deal with the historical background of the various surgical procedures for correction of obstruction due to benign prostatic hypertrophy However it should be stated that most of the literature concerning the technic of suprapuble prostatectomy antedates the so-called era of chemotherapy particu larly the discoveries of penicillin and streptomycin.

Prior to the discovery of these new and useful antibiotics, the chief difficulty in the treatment of prostatic obstruction lay in the control of infection. Epididymitis alone was encountered in 18 per cent of the patients Routine vas ligation has practically eliminated this complication, provid ing it has been done early enough before the in fection has started up the ejaculatory ducts. Neff advocated preliminary exposure of the bladder, packing the wound open with gauze down to the level of the bladder wall 12 Three to four days later, after the wound had developed healthy granulations, the bladder was entered and a mushroom catheter was inserted for drainage At some later date, suprapubic prostatectomy was performed

I followed this procedure for almost ten years until there was access to the newer antibiotics. I continued to feel as I am sure all urologists have felt, that much time and anxiety on the part of the patient and surgeon could be saved if the operative procedure could be completed safely in one stage. It was felt also that if proper drainage could be maintained the abdominal wound could

be closed tightly, as in many general surgical procedures. My first few operations were done with some fear as to the outcome but I continued to gain courage as I noted the improvement in the postoperative well-being of the patients. The wounds healed without urinary drainage, in flammation, abscesses, and gaping wounds which so often caused delayed healing following suprapulse drainage.

There are many advocates of each of the three accepted methods of dealing with benign prostatic obstruction surgically These methods are perincal prostatectomy, suprapulic prostatectomy and transurethral prostatic resection. It is felt, however, that, on the whole the average urologic surgeon while he may be trained to perform all three types of operation skillfully, is more adequately trained to perform suprapulic prostatectomy During the past fifteen years there has been a large number of articles published on the subject of transurethral prostatic resection. and during the past six years there has been a revival of interest in perineal prostatectomy, par ticularly as regards the subject of cancer and prostatic calculi I believe that suprapuble prostatectomy has certain advantages over perineal prostatectomy and transurethral resection for the following reasons

(1) From the point of view of anntomic accessibility, it is always just as easy to get at and remove the obstructing prostate through the supripulse route as it is through the perneum

(2) Healing would seem to be promoted more rapidly in a suprapubic wound than in a perineal wound because of its position The bladder being dependent, the tendency for drainage is downward and away from a suprapubic wound.

(3) Injury to the external urethral sphincter seldom occurs in suprapuble prostatectomy and is more likely to occur both in penneal prostatectomy and in transurethral resection.

(4) The obstructing portion of the gland can be removed entirely This has no advantage over the perineal route but has a considerable advantage over the transurethral route

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(5) Other surgical conditions of the bladder, such as stone, diverticulum, or tumor, may be taken care of at the time of suprapublic prostatectomy

Lower and Harris have both recommended and described the technic for one-stage suprapubic prostatectomy with primary closure of the bladder 3-5. They reported good results, as did others, but the method did not receive widespread support and was abandoned by all but a few. The reason for the abandonment of this method lay in the difficulty of combating infection, both in the local wound and in the entire urinary tract. The failure to obtain adequate postoperative drainage due to blockage of the catheter from blood clots was another difficulty encountered

Rose now advises early, one-stage suprapubic prostatectomy with suprapubic drainage. He feels that it is unwise to prolong preoperative care beyond necessary limits and to run the added risk of infection due to the use of an inlying urethral catheter. He prefers to operate on these patients within a few hours after admission to the hospital, providing their condition is reasonably good. I feel that the preoperative use of an inlying catheter is not necessary unless one is dealing with a large amount of residual urine or with a bladder in total retention. Rose uses suprapubic drainage after operation. His results are reported to be good and his mortality rate is low

During the past five years, I have performed only one suprapubic cystostomy preliminary to prostatectomy All other patients, having obstruction due to benign hypertrophy of the prostate, have been subjected to one-stage suprapubic prostatectomy with primary closure of the wound No patient was rejected because of his physical Preoperative care varies slightly from condition that of Rose in that I usually study and prepare these patients one and one-half to three days before operation
Each patient receives a complete physical examination and medical consultation, when indicated The usual laboratory procedures are carried out, and if the patient's condition is found to be reasonably good, he is Inspection of the bladscheduled for operation der through a cystoscope is made in all cases, as is a flat v-ray film of the urmary tract Intravenous and retrograde pyelograms are made when indicated

I prefer spinal anesthesia, using novocain crystals Intravenous sodium pentothal and cyclopropane inhalation have also been used satisfactorily. A minimal amount of anesthetic agent is required in all cases, as most of these prostatectomies can be done in a relatively short period of time.

Technic of Operation

The bladder is filled with sterile normal saline Both vasa are ligated with to facilitate exposure fine silk through small incisions on each side of the anterior wall of the scrotum A small incision, varying from 1 to $1^{1}/_{2}$ inches in length, is made in the suprapubic midline The peritoneal fold is dissected from the bladder to a high level in order that the incision through the bladder wall may be made as far away from the vesical neck as possible The incision through the bladder wall should be no larger than will comfortably admit the index finger Two fingers of the left hand are placed in the rectum in order to elevate the prostate and to aid in guiding the enucleation of the gland with the right index finger of the mucosa covering the vesical portion of the prostate as possible is saved Likewise, the urethral mucosa is made to remain as long as possible by enucleating it as high up in the prostatic urethra as possible After the gland has been freed from the fossa and delivered into the bladder, it can be removed then through the small incision if sufficient care is taken In only two instances has it been necessary to separate the gland purposely into pieces within the bladder cavity to facilitate its removal If any stones be present, they too can be removed from either the bladder or the prostatic bed with scoops or forceps If a diverticulum or tumor is to be removed, the in-The prostatic fossa is cision should be enlarged then packed temporarily with dry gauze until all active bleeding has stopped

A No 20 or No 22 French catheter is then inserted through the urethra into the bladder and anchored in place with adhesive
If there is any doubt as to postoperative bleeding, a Foley bag catheter or Hendrickson modification of the same is used instead of an ordinary catheter cently, I have used gelfoam and ovycel gauze with gratifying results So far, I have noted no ill effects postoperatively from either The oxidized gauze has the advantage of being more easily pushed into the prostatic fossa with the inder finger and molded into a doughnut shape around the urethral catheter The incision in the bladder wall is closed with interrupted figureeight sutures of No 1 chromic catgut, care being taken not to include the mucosa The prevesical fascia is brought together over the underlying incision with a purse-string suture of the same ma-A small wick of rubber tubing placed against the prevesical fascia is brought out through the lower angle of the wound The fascia, subcutaneous tissues, and skin are then closed tightly with interrupted sutures of No 000 sılk

As soon as the patient is returned to his room,

the catheter is connected to a bottle to which has been applied negative pressure in order to promote dramage and prevent obstruction due to The catheter is irrigated every hour for the clots first twenty four hours, and thereafter only as often as necessary The patient is allowed out of bed the day after operation unless there is some good reason to prevent him from doing so silk sutures are removed from the scrotal wounds the day following operation, and the sutures are removed from the suprapuble wound four to six days after operation. The small rubber wick drain is removed from the suprapuble wound after twenty four hours

I have been very pleased with the way these suprapubic wounds heal. In a few instances serum or thin pus has been evacuated in small amounts from the subcutaneous tissues but in no instance has there been any evidence of infection extending below the level of the fascia wise. I have been impressed with the small amount of bleeding which we have encountered It is my impression that no more bleeding occurs when an ordinary catheter is used than when a hemostatic bag catheter is used. It has been noted that the patients in whom the hemostatic bag catheters have been used have suffered more In no instance has it been necessary to reopen the wound, and no postoperative herma has occurred

In only 2 patients did I have any unfavorable One patient died on the third postoperative day as a result of cardiac failure which, although recorded as an operative mortality, was not thought to be due to the technic used the other patient who hved, an acute suppurative funiculitis developed into an abscess which was opened in the right groin. He also developed an acute bilateral pyelonephritis due to Bacillus proteus. This was the patient who required the longest postoperative catheter drainage and who spent the greatest number of days in the hospital He was also the patient upon whom we first used streptomyon

Results

A total of 77 consecutive unselected patients have been operated on according to this technic. One postoperative death occurred giving a mor tality rate of 1.8 per cent. This was a man, aged seventy-two, who died three days after operation

from cardiac failure, secondary to arteriosclerotic heart disease He was known to be a poor operative risk. The youngest patient was fifty-one years old, the oldest eighty nine The average age of all patients was seventy-one years, with 50 patients, or 72 7 per cent, falling within the sixtyto eights year age group. Fourteen, or 18 1 per cent of the patients were eighty years or older and no fatality occurred in this group

The average time for the removal of the inlying urethral catheter was seven days after operation. the earliest being one day and the latest twenty four days

The scrotal wounds were all healed per primam twenty four hours after operation pubic wounds healed in an average of eight days. the earliest healing time for a suprapuble wound being three days, the latest twenty four days

The average postoperative stay in the hospital was fourteen days, the shortest was six days (2) cases), the longest forty five days

Conclusions

One stage suprapuble prostatectomy with primary closure of the bladder can be done safely for benign prostatic hypertrophy as well as for removal of bladder tumor, stones, or diverticula

Suprapuble cystostomy is usually not necessary unless the patient has epididymitis urethral stricture prostatic or penneal abscess, or some advanced ceptic condition in the upper urinary tract on admission If preoperative drainage is necessary, it can be accomplished safely by an inlying urethral catheter, providing both yasa are ligated at the time

The improvement in the morals of the nationt is not to be overlooked The patient is always receptive to a one-stage procedure and is happy to learn when he returns from his first visit to the operating room that no further operative procedures will be necessary

Finally, my results seem to compare quite favorably with those obtained by all other accepted methods.

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SCHISTOSOMIASIS

W GIFFORD HAYWARD, MD, Jamestown, New York

(From the Woman's Christian Association Hospital and Jamestown General Hospital)

THE discussion of this disease is appropriate at this time masmuch as this year marks the centennial of its discovery. Of still more importance is the fact that during the recent war, our troops served in areas where the disease is endemic, and enough cases are being brought to light so that it behooves us, as urologists, to reacquaint ourselves with the history, life cycle, symptoms, and treatment of this infestation. There is scarcely a town in the United States, no matter how small, that has not had some man serving in Leyte, China, Africa, South America, or the Caribbean area.

The likelihood that the disease may gain a foothold in this country is remote, since only certain species of snails act as intermediary hosts. Experimental work up to this time has failed to produce infestation of any snails that are indigenous. This statement must be qualified to some extent, however, since the studies of Cram and Files in 1945, show that 19 per cent of snails from a lake on the campus of the Louisiana State University shed cercariae of Schistosoma mansom. This occurred after they had been exposed experimentally to an infestation of Schistosoma mansom

The author's interest in this subject was occasioned by the discovery in 1937 of a case of vesical schistosomiasis caused by S japonicum, one of the few cases on record and the discovery of a second case in 1946, caused by S hematobium in a soldier who had served in Africa, it seemed advisable to contact as many as possible. A search was made through the files of the draft boards, and in this manner the names and addresses were secured.

Questionnaires were sent to 98 men who served in Africa, with 32 replies

To the first question, "Did you bathe or go swimming in fresh water?," 13 replied no, and 19 replied yes—To the question, "Did you drink any unboiled or untreated water?," 20 replied no, and 12 replied yes—To the questions "Did you have any itching of the skin after bathing? Did you have fever or loss of appetite two weeks or six weeks after bathing?," the answers were practically 100 per cent negative—To the question, "Have you had any bladder symptoms such as frequency of urination, burning, bladder pain, or blood in the urine?," 5 reported that they had ex-

perienced frequency, and 3 reported that they had experienced burning

Letters were mailed to all those who had bathed in fresh water, requesting them to come to the office for further questioning and examination Only 9 appeared. None were found to have a leukocytosis or eosinophilia, and in only one urine were suspicious bodies found which might have been ova

Questionnaires were also sent to 200 urologists in New York State, and 104 replies were received Of this number only 5 replied that they had seen any cases Two of these had seen their cases The other 3 had seen them in while overseas this country One reply was from the United States Marine Hospital on Staten Island, stating that "quite a few cases" were being seen. It is guite apparent from the responses that either very few cases of infestation with S hematobium have occurred in the troops, or else they are not being Both of these alternatives would recognized seem probable Stebbins reported 24 cases of S manson and no cases of S hematobium or S japonicum identified at Washington Heights Health Center since 1941 3

History

In 1847, Katayama disease was described Many years later it was named S japonicum 4

Bilharz, in 1851, discovered the parasite of S hematobium, although the disease was known to exist in ancient times and has been found in mummies. His name has continued to be identified with it as Bilharzia hematobia or Bilharzia disease.

Weinman, in 1858, described the genus Schistosoma and the disease, commonly called schistosomiasis, because the parasites all belong to a common genus ⁵

In order to spare you a session with a textbook on tropical diseases, a résumé of the life cycle, symptoms, and treatment of the disease will be attempted. Although we are interested primarily in the S hematobium which produces urologic symptoms, the life cycles of all the Schistosoma are so similar that they will be considered as a group first. The intermediary host in all cases is a fresh water snail, but a particular genus and species is necessary. The S hematobium inhabits the genus Bulinus, the S mansoni the Planorbis, and the S japonicum the Oncomelania.

Humans and mammals that are susceptible

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acquire the infection by bathing or otherwise exposing their skin to fresh water which is infested with cercariae, the fork tailed larval stage of develonment seen after the Schulosoma have left the body of the snail. These cercanse bore their way through the skin or mucous membranes dropping their tails in the proces. After they have reached the capillanes the b'ood stream earnes them to the right side of the heart and to the lungs, reaching the general circulation by traversing the candlaines of these organs. It is a peculiar phenomenon that only those organisms which reach the mesenteric artery and gain access to the portal circulation survive. Others act only as emboli and may or may not produce local symptoms. Having reached the intrahepatic circulation, the former become adole-cent worth. in about two weeks at which time they begin to migrate against the current Schistosoma janonicum migrates to that part of the intestinal wall dramed by the superior mesentene vem, taking from one to two weeks to do so S mansoni migrates to that portion of the intestinal wall drained by the superior and inferior mesentene vein which takes about twice as long, and a hematobrum migrates through the inferior mesonteric and hemorthordal anastomoses into the vesical venules requiring about eight weeks to reach this location. The worms now are ma ure the male measuring about 1.5 cm, in length and the female 2.5 cm. The male is broader than the female and in the vein les wrapped around the female. When egglaving start,, the female leaves the male, and because of her narrower diameter, she can and does pul into the timest venule. She withdraws as each erg is laid, and the size of the egg which is greater than the size of the venule plu, the spike at its end tend to ho'd the ovum in place A ferment secreted through the egg shell soon breaks down the venule and the mucosa of the bladder allowing the egg to gain access to the bladder Egg-laving continues during the Lie time of the womes which is estimated to be thirty years

After the egg is worded it rup uses due to ormotic pressure, and the minordium emerges and swins about. However if the egg does not reach fresh water, it dies within twenty-four bours. If a mollusk of the genus Buhnus inhabits the water it is penetrated by the minaudia. In the body of the anall, sporocysts, daughter sporocysts, and finally forked-tailed cereanize develop from the minimals and escape spontaneously into the water thus completing the cycle. The portion of the cycle in the small takes about fourteen days.

Symptoms

The early symptom, will be mentioned only briefly because they are variable. Itching or

recelling rain may occur as the cereana pentrates the skin. Fever anorexia, and malaise may ensue about two weeks later. Gastrointestinal evinptoms and tenderness over the liver may be present during the intral epatic cycle. After the ova are deposited, there may be fever again 25 a reaction against them. Leukocytosis and an eosmophilia with or without leukocytosis may occur. From this time on, bladder symptoms may appear consisting of dull, suprapuble pain, a feeling of heaviness frequency of unnation, burning on voiding, pyuris, and hematuris. The inconsistency of the symptoms is illustrated by a ease that had multiple exposures with no itching. fever or symptoms of any hand until the patient had been out of Africa for about aix months that time he began having a pressure feeling in the bladder and a constant desire to void. symptoms lasted only twenty-four hours was no hematuna. Exposed in 1943 and expenenging his first symptoms in 1944, he had in all about seven or eight short episodes before I saw him in April 1946 and placed him on treatment

Another man to d me that many of the troops in his outfit had frequency and nocture while they were in Africa but they took it as a matter of course.

Diagnosis

This first of all, is based on the history of exposure.

Alves and Blair in a large series of cases from Southern Rhodesia used a cereanal antigen intradermal kin test successfully *

Finding the terminally spiked egg in the unners most important. Eosmophilis while not constant should be looked for also

Treatment

The disease is successfully treated with antimony but this treatment dates back only a few In looking back through my medical school textbooks. I found that Sallman in 1912. and Hare in 1916, made no mention of its use for this disease. Solis-Cohen, in 1928, stated that its chief value i. in the infestations of animal parasites, both proforcin and metazonn. We find that emetine was used as a secret remedy in Expt prior to 1917 It was abandoned because (a) it was not as effective as antimony-(b) it was toxic to heart muscle (c) it produced pempheral neuntr. and (d) it was too expensive. Many forms of antimony have been used. The trivalent form is efficiencies—the pentavalent form is not

The United States Army according to its 1945 Method Bullatin allowed no other treatment than tartar emetre intraverously or foundin intramuscularity. Authors do not see eye to eve on

One group maintains that the respective ments while tartar emetic is more toxic, cure is quicker, and the end results are better 68 The other group with a large series of cases to back them up maintains that foundin is the drug of choice Certainly, found is easier to administrate and in my very limited experience has been entirely satisfactory Detailed directions for their use will be omitted

Prognosis

In treated cases the prognosis is excellent should be remembered that the more frequent the exposure, the more massive the infestation and conversely It is probable that none of us will ever see a case with massive infestation Yet, if we again remember that the worms may live for thirty years and continue to lay eggs, it will be surprising if, later on, symptoms do not These can be enumermake their appearance ated as follows chronic cystitis, upper urinary tract symptoms due to stricture of the lower ureter, calculi, papilloma and carcinoma, prostatitis and vesiculitis, anemia, rectal symptoms and, in rare cases, pulmonary symptoms

Comment

Although the responses to questionnaires show that few cases of S hematobium have appeared in New York State, the possibility of seeing such a case is greater than ever before It should also be remembered that S japonicum and S mansoni have been known to invade the bladder, and a careful history and careful examination of the urinary sediment may furnish surprising results 319 PINE STREET

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ANNOUNCEMENT

Section on Radiology, Quiz Program

Quiz Program to "stump the experts," using x-ray film, at the Annual Meeting, Мау 20, 1948, 10 ам

Please send problem films in which a diagnosis has been established, with brief résumé of relevant information, to

> Dr Marcy L Sussman Mt Smai Hospital 1 East 100th Street New York 29, New York

Do not send diagnosis Identify your material carefully so that it may be returned

TRANSURETHRAL SURGERY IN PATIENTS PAST EIGHTY YEARS OF AGE

WILLIAM A MILNER, M D, Albany, New York (From Albany Medical College)

TRANSURETHRAL resection offers patients past eighty years of age relief from a condition which cannot be treated safely, except in unusual instances, by any of the other methods known to urologists

In the past most patients of eighty years or more have been told they were too old for surgical relief of prostatism and unfortunately, a

few are still of that impression today

This group of patients are far from what we would classify as good surgical risks Practically all of them have myocardial damage, and many are infirm in other respects On the other hand, many men of eighty are better risks than some induviduals many years younger

One general concept is followed in handling these patients. If they can be prepared for surgery, then, in most instances they will go through the operation without difficulty. In other words, their blood chemistries must bear some semblance of the normal and their circulatory mechanism must be compensated, even though it may be extremely poor

Any complication, arising during the convalescent period following operation greatly increases the mortality rate in these patients. Sedatives must be employed with great caution, for any deep sedation may well result in a pineumonia.

Psychosis, coming on transiently, after surgery is not uncommon. This is especially apt to occur in those cases which show some signs of mental

semuty preoperatively

In the vast majority of cases this clears up spontaneously. In the few where it persists, the patient sometimes clears more rapidly when he can be returned home to be natural surroundings.

can be returned home to his natural surroundings
Great care must be taken to keep these cases
out of bed as much as possible Fewer complica-

tions occur if this course is followed

The preoperative preparation consists of the following course

1 Where necessary eatheter drainage should be used to reduce high blood chemistries.

- 2 Cardiac conditions should be handled by medical consultation and treatment when these measures are deemed advisable
- 3 Urmary output should be kept at a high level by forcing fluids
- 4 The patient should be kept out of bed as much as possible
- Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Urology May 7 1947

- 5 Sedatives should be used spannigly unless necessary to provide the patient with sufficient sleep
- 6 An opato, or one of the rapidly secreted barbiturates, in small doses seems to be best in the way of drugs. Small doses of scopolamine are sometimes helpful
- 7 No preoperative sedation is given, except a large breakfast which seems to have a very

"soul-satisfying effect."

8 An enema is given the night before operation

Operation is done as quickly and completely as possible, although completeness of the resection should never be sacrificed for time unless there is some definite indication of a need for it. The postoperative morbidity is greatly reduced by complete removal of the gland down to the surgical capsule. Blood loss should always be kept at a minimum, and if it should be excessive, transfusion should be prompt and adequate. I do not believe this is necessary in more than one per cent of the cases.

Patients are given a medium back rest im mediately after returning from the operating room and encouraged to drink copiously. One or two liters of fluids are given intravenously, and the patients are allowed a diet as tolerated after their first meal which consists of liquids.

Should there be any pain or discomfort, small

doses of morphine are given

Patients are usually allowed out of bed on the second day and encouraged to be up as much as possible. As soon after the seventh postoperative day as they are strong enough to take care of themselves, the patients are discharged from the hospital.

Review of Cases

Since January, 1942, 180 patients of eighty years or more have been operated to relieve symptoms of prostatism. This represents 109 per cent of the total number of cases operated for this condition during this period.

Age Five of these cases were over ninety years of age, the oldest being ninety-eax. The average age of the entire group was eighty three and autenths years

Weight of Gland Fifty-one of the cases had glands weighing 50 Gm. or more and 13 of them had glands weighing more than 100 Gm Residual Urine Sixty per cent, or 108 cases, had complete urinary retention, the other having varying amounts of residual urine

Pathology Fifty-nine cases, or 327 per cent, were carcinomatous, 7 had associated bladder calculi, 13 had prostatic calculi, 6 had, in addition to their prostatic difficulty, cancer of the bladder, and 5 had had cystotomy elsewhere

Morbidity The average hospital stay of a resection case is from seven to ten days. The total hospital stay of these patients was a little longer on the average, due to long stays in a few instances.

All cases were able to void freely on discharge from the hospital, and the only cases of incontinence which occurred were in those in which sensity overrode neatness

Mortality Eleven deaths occurred in the entire group which is much higher than should be expected in a total series of prostatics including all ages. This was 6.1 per cent, as compared with a

mortality of about 2 per cent for the entire series over the five-year period

Strangely enough, 10 of these deaths occurred in two of the years, whereas there was only one death in all the cases of the other three years

Analysis of Mortality There were 5 deaths from cardiac complications, 5 from pneumonia, and 1 in which the cause was unknown

Conclusions

- 1 To obtain good results, meticulous attention must be paid to all details both pre- and post-operatively
- 2 Cancer of the prostate is far more prevalent in this age group than in younger men
- 3 Although the mortality of operation is 6 per cent, the mortality of untreated prostatism approaches 100 per cent
- 4 Men past eighty need no longer be told they are too old for surgery

75 WILLETT STREET

ANNOUNCEMENT

1948 Medical Directory Deadline

All material for the 1948 Medical Directory of New York, New Jersey and Connecticut should be in the office of the Medical Society of the State of New York before April 15, 1948

No corrections or additions may be made after that date

WHAT IS A STATE MEDICAL SOCIETY?

The Executive Secretary of the Connecticut State Medical Society, Creighton Barker, M.D., has this to say

"I have asked myself, 'What is a state medical society?' Is it a scientific and educational organization as we would have the Bureau of Internal Revenue believe? Is it a protective guild of skilled craftsmen? Is it a polite device for spreading propaganda? Is it a special minority for influencing legislation? Is it a social club through which one may extend his acquaintance and prestige? Is it an institution for public service? Of course no single answer is enough. Medical societies try to be, and are, combinations of them all. Some emphasize certain things more than others, with varying degrees of success, but this is what they try to be It is complicated, isn't it, when you stop to think of it? And it is further complicated when it is

acknowledged that a society—any society—is people. It is people that confuse it most and the people who make up a medical society are something special, all educated, mostly intelligent, quantity conceited, strict individualists usually with a common interest and peculiarly unselfish. Mix them all up and add a few honest and some bogus idealists and a spatter of the unscrupulous and you have a medical society, an organization the like of which is hard to find.

"At the last I want to say that the profession of medicine is not just a company of odd little men each intent on making as much money as he can There is something in medicine that is bigger than any one of us and that fine bigness can find its expression best through our medical societies"—News Letter, Council on Medical Service, A M A, January 31, 1948

Special Article

OCCUPATIONAL DISEASE—THE INSURANCE VIEWPOINT

HENRY D SAYER, New York City

(General Manager Compensation Insurance Rating Board New York)

TO THE extent that compensation laws play a vital part in our social and economic life insur ance has served, and will continue to serve an essential interest in our industrial system In so doing it performs a public service in a high degree view of the matter it is of little consequence to insur ance as such, what the coverage under the law may It is sufficient that the obligation is insurable that it is sufficiently definite and described to permit the setting of reasonable and adequate rates, and that it is expressed in definite and certain language so as to be readily understood by those affected by it and to warrant fair administration and the avoidance of wastefullitigation

While it may be assumed that the original purpose of compensation statutes was to cover only disability and death due to injury by accident possibly because injury to health gave no right of action against the employer under the old common law logically no one can disagree with the principle of compensa tion for those diseases that are as definitely occupa-tional as are industrial accidents. In many juris-dictions diseases to be compensable under the law must be due to causes and conditions characteristic

of and peculiar to the occupation.

Industry and insurance have joined in advocating passage of occupational disease laws. Insurance has urged in various places and on various occasions that these laws be drawn with such directness and ex plicit terminology that there be a correct under standing of the rights and obligations created there-

by leaving little room for litigation.

We are not particularly concerned at this gather ing with those diseases and infections that follow naturally and unavoidably from injury caused by accident we are concerned rather with those diseases that result from conditions in the employment caused by exposure to or contact with toxic substances, radioactive emanations, exposure to danger ous dusts gases or fumes or other conditions necessarily present and characteristic of a particular em-ployment. More particularly are we here concerned with those diseases affecting the lungs and respira-

tory tract.
The greatest difficulties have been encountered in the consideration of micosis and asbestosis as occu pational conditions. While diseases of the lungs due to inhalation of dust have been recognized from the earliest times and have been referred to in the ancient literature until recent years little was known scientifically of their pathology etiology and thera peuris. Medical science in recent years, especially under the inspired leadership of Drs. Trudeau and dealt the company of th Gardner has made great strides in research and the determination of the facts as to the nature and development of these diseases. Over the years while a worker is being exposed to dust and is very slowly

acquiring pathologic changes that may eventually result in his total disablement or death, he may be employed by a number of different employers of have sporadic employment for the same employer, and in these various employments conditions may be very different, and the character and concentration of dust may widely differ. His employments may not all be within the same state and may be governed by different laws. His various employers may have been insured by different insurance carners. The right to compensation having been established, the worker or his dependents are concerned only with the receiving of the benefits set forth in the law and have no particular concern with respect to the carrier that is liable for such payments. But the deter mination of those questions is the responsibility of the administrative authorities.

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Similar complications arise when the law creating the liability for benefits is of more recent existence than the period of exposure from which the condition arose. Thus, a period of total disability may arise within a very brief period after the enactment of the new law, while the period of exposure out of which the disease arises may almost complicely antedate the law creating the liability. Here then a condi-tion may arise for which liability is newly imposed by law while the conditions out of which the disability arose may be wholly or in large part due to conditions of employment at a time when the law created no liability upon the employer or his insurer

for such a disability

Recognizing these manifest facts, the New York State Legislature accepted certain very important principles in enacting the law with regard to the pneumoconioses namely, that the liability for com-pensation shall be imposed wholly upon the em-ployer who last employed the worker in a dusty employment and that the liability for allicosis or asbestosis under the new law shall be in the beginning merely minimal taking little account of the exposures in employment which took place prior to the law's enactment. The benefits however were in-creased gradually until full and unlimited benefits are

payable.

By fixing the liability on the last employer in a dusty exposure there is avoided endless difficulty in attempting to assess upon each employer by whom the injured person was employed his proportion of liability for the entire condition This would be a

manifestly impossible task

By always assessing the liability on the last employer, the principle of distribution of cost brought about by insurance makes such procedure fair and it averages out fairly

A somewhat different and very complex question is presented in the matter of compensation for par tial disability from allicosis or asbestosis. At a superficial glance, it might be assumed that partial disability should be componented in the dusty trades the same as it is in the case of injury due to accident.

^{*} Condensed from a paper read at the Sarause Symposium on Tuberculosis, Sarausa, New York, October 3, 1947

But upon slight reflection, it will be recognized that a

very different situation must be faced

In the first place, just what do we mean by "partial disability" in dust disease of the lungs? Having in mind the infinitely slow progressive nature of the disease, at what point does it become partially disabling? And how is that disability to be measured? Do we think of partial disability as a mere physical condition, or must it be both physical and economic?

There are a great many workers in dust, perhaps more than we realize, who have definite lung pathology, demonstrable clinically and by v-ray, that may be deemed a partial permanent physical impairment, but who have, nonetheless, a full earning capacity These men do a full day's work, are fully productive, and earn full wages when they have jobs Should we say these men must be compensated? If so, for what and how much? We cannot compensate them for loss of earnings, for they have suffered no such loss, nor can we compensate them for inability to get jobs, for they have jobs when work is Their skill, born of years of experience, has been found in many instances in practice to offset any supposed unemployability due to physical impairment, and unless they make claim for compensation and are physically examined, an employer does not know of the existence of any degree of fibrosis in their lungs, whether partially disabling or

It is certain that in some trades the workers prefer not to know that they have a mild degree of silicosis, and they assuredly do not wish their employers to learn of their condition through physical examinations. They seem to prefer jobs and the wages that they earn to any compensation allowance and to the certain branding of them as silicotics that would be entailed in any system of compensating for partial disability. They appear to regard that as economically disastrous, and there can be little doubt of the bad psychologic effect of such knowledge.

In cases of partial disability from silicosis or asbestosis, partial disability, if it arises at all, comes on gradually and insidiously Physical findings by xray are usually the first evidence of the disease Never is any disability present at the outset Progress is not toward improvement, as is the case in recovery from traumatic injuries, but if exposure continues, the disability increases—It may progress slowly to eventual total disability, or the worker may continue working almost to the time of his eventual death

To the medical man these distinctions may not be very significant, to the administrator and to the insurer they are vital. If a worker is compensated for partial disability in a dust disease case, it is almost a certainty that he will continue under partial disability until total disability or death occurs. Total disability will not be long in following the partial disability, for once the worker is officially certified as a silicotic, his days will be numbered in his trade.

Insurance under the law for partial disability would present almost insuperable difficulties. In the first place, we have no reliable facts as to the number of workers at any time who have silicosis or asbestosis in any degree, whether partially disabling or not. What the exposure is, or may be, we have no way of knowing. Accordingly, this would raise serious difficulties in the way of fixing insurance rates that would be both reasonable and adequate. The setting of proper rates is at the very basis of effective insurance.

If one recalls the principles referred to at the outset of this paper, it would seem that so far as the New York State law is concerned, the obligation for occupational diseases has been made insurable, susceptible of rating, and is stated in reasonably definite and certain language. Insurance may be relied upon to do all in its power to make such laws workable and effective to accomplish the objectives set before us

CORRESPONDENCE

Further Note on the Specialty Boards

To the Editor

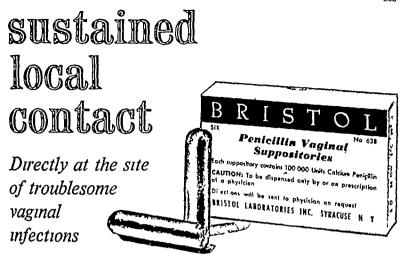
I would like to express my agreement with the opinion of Dr M S Lloyd in regard to the tactics of the Specialty Boards, as stated in his letter published in the Journal, February 1, 1948. Although within the past twenty years the field of peripheral vascular diseases has assumed the status of a distinct specialty and is recognized as such, not only by the profession but also by the New York State Labor Department with a distinct designation of SM 16, the Specialty Boards refuse to recognize this subdivision. Instead, they allow the peripheral vascular specialist to smother himself under the classification of general surgery or general medicine. The inconsistency of

this is evident in the fact that the competent peripheral vascular surgeon must be well versed in both medicine and surgery and would, therefore, under present regulations, have to qualify in both fields

It seems to me that the state medical societies can exert sufficient influence to review, and perhaps revise, the present standards of specialization arbitrarily set up by the self-instituted boards

> (Signed) SAUL S SAMUELS, M D 151 East 83rd Street New York City

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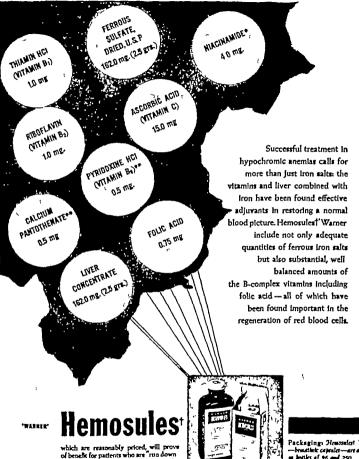


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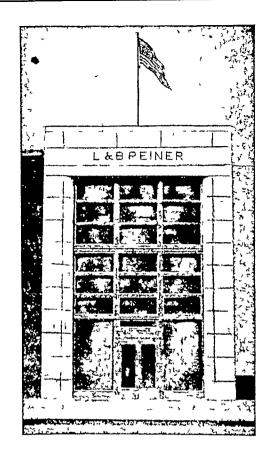
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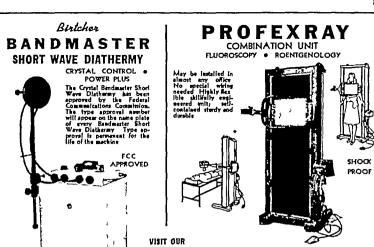
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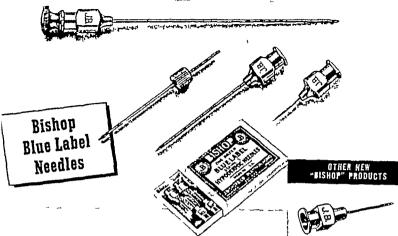
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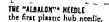
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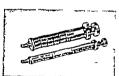
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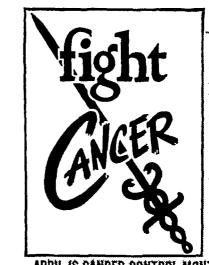
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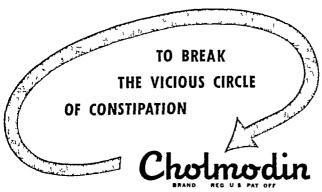
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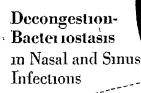
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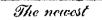
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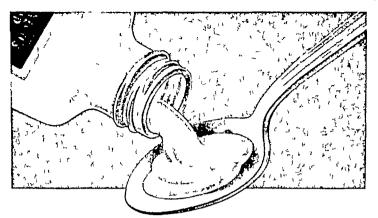
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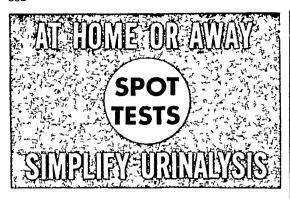
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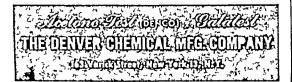
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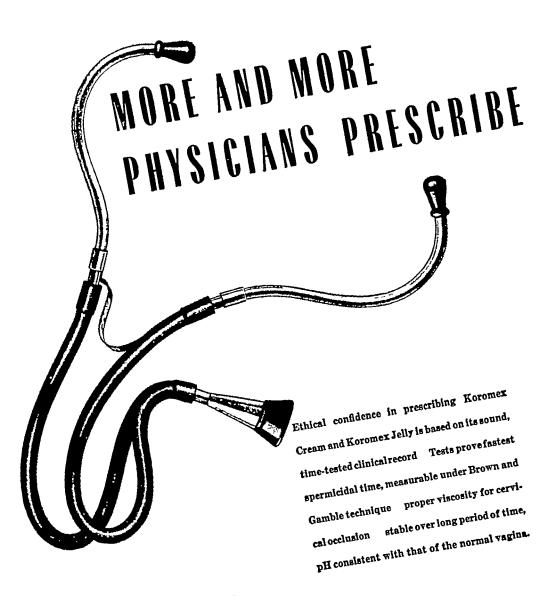
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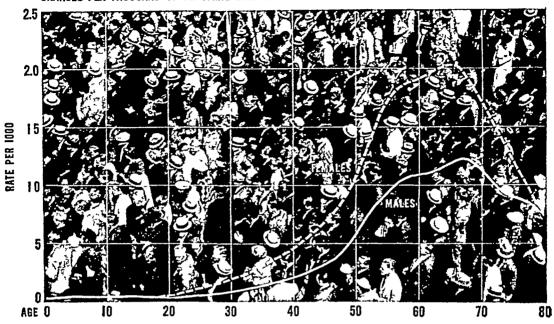
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1 Spiegelman M. and Marks, H H: Am J Pub Health 36:26 (Jan) 1946 2. Statistical Bull Met Life Ins Co 27 6 (Feb) 1946

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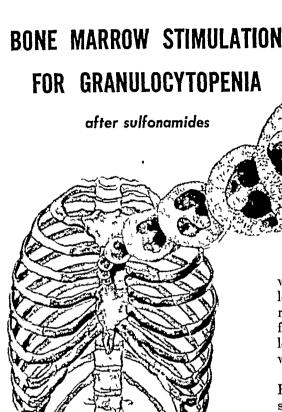
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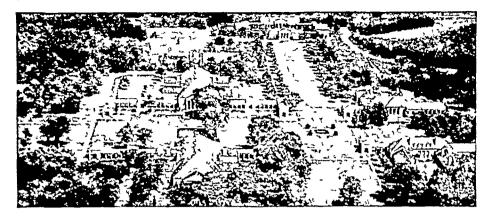
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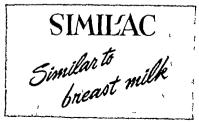
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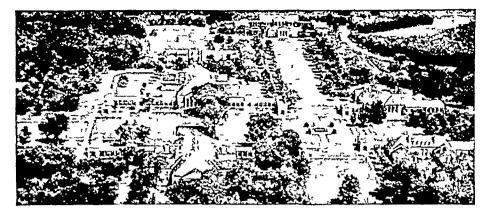
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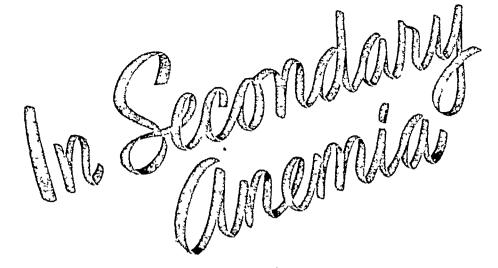
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Albrecht, F. K. Modern Management in Clinical Medicine, Baltimore, Williams and Wilkins, 1946 page 659

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*Fishberg, A. M.: Heart Failure, Lea and Febiger Philadelphia 1946 p 733

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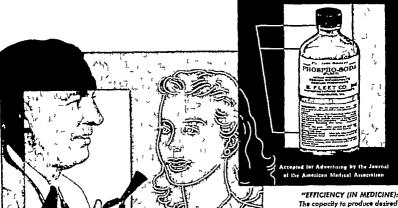
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2. Gold, Herry In Ceefer nece en Theropy: N. Y. St. 1. J. of Med., Mor. 1. 1947. 3. Jedd, E. S. Am. J. Surg. 74. 444. 1947.

4. Morpo, C. W.a. Preceedings Internates Port-Oreduen Med., Assembly et North America, 1942. 5. Nessirod J. F. et al.: Illinois Med. J. 81.4, 1942. 6. Ch. biopher F. Misor Sergery. W. B. Sound on Co. Philodelphia, 5th. 4ed. 1944.

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Editorials

Socialism and Medicine in Great Britain TT

In a previous editorial we wrote of the situation of the medical profession in England with respect to an expanding government program of nationalization of resources and services in that country 1 We touched on the fact that such a program as that of the Labor Government flowed from the popular will through the medium of free elections, and that therefore there was a broad base of popular demand in a nation approaching the problem of possible bankruptcy realistically. for the inclusion of medicine in the socialistic program

We now learn that the nationwide plebiscite taken by the British Medical Associa tion of Britain's medical practitioners, specialists, and consultants showed an overwhelming majority (86 per cent) against working for the universal free medical service scheme of the government scheduled to take effect July 5 2 More than 56,000 doctors, including alien physicians in Britain and Britons overseas and in the military and naval services were polled, and, of the total ballots sent out, 82 per cent were returned This figure seems evidence enough of the interest of the British medical profession in the vital issues at stake

¹ April 1 1948.

1 New York Times (Feb. 19) 1948.

Since 1911, the general practitioners of Great Britain have participated in the medical insurance scheme instituted by the Lloyd George government to provide medical service for low income workers ticipating to an average of 40 per cent of their income are all but about 1,000 of the nation's 20,500 general practitioners older insurance scheme would be supplanted by the present Labor Government's new Act

As a result of the B.M.A 's poll it would appear "that the government would have a maximum of 3,560 general practitioners and 271 consultants and specialists to oper ate a health service designed for a population of 47,000,000 "2 This number apparently goes along with the government, al though it is not stated how many of these physicians are members of the Socialist Medical Association

The Representative Body of the B.M.A., at its meeting in March of this year, recom mends non-cooperation with the Labor Government's health service as a result of the plebiscite Even so, this does not mean that the people of the nation will be deprived of medical service, or that a "physicians' strike" is contemplated. This would be unthinkable, and no physician anywhere would even contemplate such action, no

matter what the provocation might be Nor does the profession of Great Britain intend to penalize the people It would continue, as at present, to treat patients and to request payment for services ren-Where payment was not forthcoming, the professional attention would be given free Not all doctors, it is contemplated, would be able to do this without suffering from inability to collect fees, however devoted they might be to the cause of a free profession To meet this contingency the BMA is now raising a "hardship fund" to tide over those medical men who might otherwise be driven into the government scheme by the power of the public purse 3

The situation of the medical profession in a changing world, as represented by these happenings in Great Britain, deserves careful study by the profession in this country Why is this so? Because for some time it has been realized that, within the framework of the federal government, specifically within the Bureau of Research and Statistics of the Social Security Administration in this country, definite pressure and propaganda has been emanating for federal control of medicine via the Wagner-Murray-Through the spring-Dingell proposals board of hearings on this measure, all well publicized, and through such devices as the "health workshops," and doubtless by still subtler propaganda measures, an attempt 3 About \$1 600 000

has been made to manufacture a demand for government controlled and regulated practice of medicine here

How successful have these attempts been? Apparently not yet too successful Why? Because (1) the economic stringency has not yet become sufficiently great. (2) the population increase and the growing burden of the national debt has not yet turned the attention of the public to the acceptance of a frank socialist program of nationalization of resources and services as a means of temporizing with the specter of national bank-But events move rapidly in this And while the electorate has not, at this writing, installed a socialist government here, a great deal of socialist ideology has permeated the thinking of established political parties and the vast army of civil servants who staff the numerous bureaus These latter, living on fixed and, in the main, madequate salaries in a period of inflation, could be sympathetic to a tax-supported medical service, and the teachers in the public schools system might also be lured with many others by the same bait

The American Medical Association, the state medical societies and many individual physicians are aware of what goes on both abroad and here. So far, no legislative act has progressed to the floor of Congress or the state legislatures to crystallize opinion in the profession of medicine as the National Health Services Act has done in Great Britain.

Prophylaxis of Ophthalmia Neonatorum

Since Credé first announced that the instillation of a dilute solution of silver mitrate would prevent gonorrheal infection of the eyes of the newborn, with its often disastrous consequences, a worldwide acceptance of his proposal has followed, and the results in reducing the incidence of this disease are well known. However, ophthalmia neonatorum is still with us, whether due to carelessness or forgetfulness or improper application, by the attendant in childbirth, of what is essentially a simple

procedure The sanitary codes of most American states and cities require the prophylactic instillation of silver nitrate or, as in the case of New York City, "an equally effective agent"

In considering a substitute for silver nitrate, many questions arise. These have been studied in a very complete report made by the Public Health Relations Committee of the New York Academy of Medicine in response to a request from the New York City Commissioner of Health for

an opinion as to the desirability of changing the Santary Code to accept penicillin as a substitute. In this connection, attention must be directed to the questions of effectiveness, safety, feasibility, concentration, mode of application, allergic reaction, and recurrence after treatment. Penicillin, because of its now great popularity as an infallible antiseptic (if we may call it so) has developed several advocates—Lchrfeld, Franklin, and others in this country, Sorsby in England.

Mention must be made of the fact that ophthalmia in infants is not necessarily gonorrheal There may be other organisms involved-streptococci, staphylococci, pneumococci, coliform organisms, and viruses Many of these are strains resistant to penicillin. Proof of the effectiveness of the latter does not, up to the present, appear Moreover, the most effective concentrations and the best method of application have yet to be determined Solutions must be fresh, and several in stillations are required In unskilled hands it may not be so simple as a single instillation of silver nitrate for prophylactic administration

The special committee which made this study did not recommend any change in the Sanitary Code of New York City, although it did suggest that hospitals, under adequate control, be encouraged to make further studies

The Special Committee of the Academy considering the problem includes in its personnel an ophthalmologist, a pediatrician and an obstetrician. Their opinion that the use of silver intrate should be continued, pending further study of the value of and practical considerations relating to the use of pencillin, preserves a tried and proved remedy in the use of which professional personnel have been trained over a long period of time

Since this editorial was prepared, there has been published in one of our popular woman's magazines an article with a lurid title, "Can Present Laws Blind Your Baby?" It was written by Miriam Zeller Gross, who claims that babies are often rendered blind from the use of nitrate of silver as a prophylactic because the law in many states compels its employment by physicians. She claims that this disaster can be avoided by substituting penicillin for nitrate of silver However, this is by no means proved, and it would, in our belief, be a calamity if a tried and certain method were discarded without further experience with another which has by no means been shown to be superior Perhaps there is a substitute which causes less reaction than silver nitrate, but we had better know more about that before the claim of infallibility is disseminated

1 Woman e Home Companion, (April) 1945 p. 33.

Education in a Jet-Paced World

New medical problems are increasing even faster than new medical knowledge, in the view of some educators. To meet this challenge to the teaching profession, there was planned a meeting of educators at Buck Hill Falls, Pennsylvania, apparently the first of its kind

Elhott Dunlap Smith, provost of Carnegie Tech, was selected chairman of the planning committee. Interviewed after his election, Professor Smith explained that the conference plan was born in the summer of 1947, when educators realized they were not able to keep up with advancing knowledge in this "jet-paced world." He predicted a doctor or a lawver would be helpless in three

years if he stopped studying on graduation from professional school.

A moral renaissance among professional men is also being proposed. They must be taught to see beyond their technical skills "We have to teach boys to think not 'How can I do my stuff?' but 'What should be done?' when they meet a professional problem

"Our education is bogging down at that point," he warned "It must be inbred in a doctor or lawyer to consider not just how he can earn a fee, but what will do his chent and society the most good," Professor Smith explained

Chairmen of the three sessions and speak-

ers who "testified" for their particular professions at the meeting, known as the Inter-Professions Conference on Education for Professional Responsibility, were announced by Professor Smith Mr Smith is provost, and Maurice Falk, professor of social relations at Carnegie Institute of Technology

The three chairmen were Donald K David, dean of the Harvard Graduate School of Business Administration, Karl T Compton, president, Massachusetts Institute of Technology, and Arthur T Vanderbilt, dean of the Law School, New York University, former president of the American Bar Association.

Dean David presided at the first session on Monday, April 12, on "The Evolution of Educational Aims with Changing Conditions of Professional Practice and Responsibility" when speakers representing the five professions discussed such basic, challenging questions as what knowledge, skills, ways of thought, interests, sense of responsibility and traits of character professional education should help a student to acquire, if he is to meet present-day and future demands of professional practice, serve society well as a citizen, live his personal life well, and con-

tinue to learn and grow as a professional man, a citizen, and a person

On Tuesday, April 13, the second conference session, under the chairmanship of President Compton of MIT was devoted to "Content and Methods of Instruction in Professional Subjects," and dealt with such questions common to the various professions as the relative effect of lectures, demonstrations, laboratory work, discussion classes, case study, and similar methods upon the development of professional students, and also to the problems to which they give rise

Speakers for the Professions at this session were James H Means, professor of clinical medicine, Harvard Medical School, medicine, James W Culliton, assistant director of research, Harvard School of Business Administration, business, Karl N Llewellyn, professor, Columbia Law School, law, B Richard Teare, head, Department of Electrical Engineering, Carnegie Institute of Technology, engineering, Rollin Fairbanks, Institute of Pastoral Care, Massachusetts General Hospital, divinity, and Eleanor Cockerill, professor of social work, University of Pittsburgh, medicine as viewed by a social case worker

Current Editorial Comment

Business of Curing Sick People "I am profoundly convinced, after eighteen years in government," said the Governor, "that government can never do any job as well as private enterprise. The job of running voluntary hospitals can best be done by free individuals and not by those under the constriction of the business of running a government."

Earlier in his speech Governor Dewey assailed politicians who "want to relegate the business of curing sick people to the dead level of government mediocrity"

Later, "Doctors," he said, "working under constant mental and physical strain, are not paid commensurately with their

efforts" "And," he added, "about all they get out of it is that some politicians would like to socialize them and bring them down to the level of servility"

"If we don't meet the great challenge of our times as free men," the Governor continued, "government will meet them But it will do it less efficiently, more expensively, and less humanely than by indi-

vidual initiative "1

The French have a proverb to the effect that all comes eventually to him who knows how to wait We can add nothing to the Governor's statement except praise for his forthrightness

¹ New York Times (Feb 21) 1948

Scientific Articles

CHOICE OF PROCEDURE IN OPHTHALMIC PLASTIC SURGERY

ARTHUR E SHERMAN M.D., East Orange, New Jersey

(From the Surgical Service O Reilly General Hospital Springfield Missouri)

DURING the past few years I have had the opportunity to observe the results obtained from a great variety of procedures used in the ophthalmic reconstructive surgery required by a large number of battle casualties of the recent war. It is my purpose in this paper to point out those procedures which I feel were most useful, as well as to mention some that should be avoided. The opinions expressed are based largely on the experience of myself and other officers assigned to the eye service at O'Reilly General Hospital from 1944 to 1946 and are based also on discussions with other men engaged in this work at other Army ophthalmic and plastic centers.

There can be no question that Dr John M Wheeler contributed more to ophthalmic plastic surgery than any other one man 1 It is only natural that many of his methods were of extreme use to us. His principles of simplification and avoidance of the use of pedicle flaps or other procedures often causing additional disfigurement, are still as sound as they were twenty years ago

There are a number of general principles that should be familiar to those who attempt ophthalmie plastie surgery The early, accurate repair of lacerations about the orbital area with excision of macerated tissue and careful closure of subcutaneous tissue, as well as the skin will often make later repair unnecessary after burns of the eyelids or after the initial repair of lacerations at is evident that cicatricial ectropion is beginning to develop the use of lid adhesions for two to three months may be sufficient to prevent that deformity The correction of deformities resulting from laceration or burns usually should not be attempted for three to four months after the initial repair because scar tissue has by that time become compact and relatively avascular Scar tissue should be as thoroughly excised as is possible and the tissues, that, whenever possible eyelid structures should be used for eyelid structures. This is too often overlooked by the general plastic surgeon Procedures should be as simple as possible to attain the desired result. Except in very minor procedures, a good, evenly distributed pressure dressing is very important. That described by Pfeiffer is one of the best.²

At times simple excision of scar tissue or tumors in the region of the cyclids, with undermlining and careful closure of the surrounding normal tissues, is all that is required. In one case a large pigmented nacrus of the lateral canthal and cheek area was excised and the defect repaired by simple closure of the normal tissues (Fig. 1). A small amount of this beingn growth, involving the cilia line was allowed to remain rather than make the repair more complicated. Another case illustrates the excision of a superficial basal cell epithelioma of the lower cyclid and simple closure of the skin, combined with a lid adhesion for three months to prevent extropion (Fig. 2)

The downward and lateral displacement of the nasal end of the lower cyclid is a not uncommon deformity resulting from improper repair of lacerations through this area. The correction of this deformity should be quite satisfactory if one adheres to several points mentioned by Wheeler over twenty-five years ago ¹ Scar tissue must be excised and the lid well mobilized. Subcutaneous tissue should be well closed, and these sutures, as well as the akin sutures, should distribute the tension so that the nasal end of the lid lies in position without tension. A small tongue of denuded tarsus anchored in a pocket up to the medial canthal ligament gives firm healing in this area.

Deformities of the medial canthal area, following trauma, are often accompanied by fracture of the bone in this area the deformity usually being a forward, downward and lateral displacement of the canthal area. At times it seems impossible to obtain a satisfactory result in these cases. An attempt should be made to anchor the canthal ligament in a position of overcorrection. To accomplish this, scar tissue, and usually the tear sac, must be excised. The whole canthal area

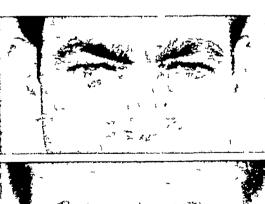
approximated without undue tension. One

abould bear in mind the often repeated dictum

Presented, by invitation, at the 141st Annual Meeting of
the Madical Society of the State of New York, Buffalo,
Section on Ophthalmology and Oriolaryagelogy May 8, 1947



Fig 1 Before and after two-stage simple excision of pigmented naevus, present since birth Entire main portion of naevus, except the part involving the eyelash region and lid margins, was excised at first operation with repair by undermining of surrounding tissue and simple closure Portion of naevus involving lid margins was excised at second operation one month later



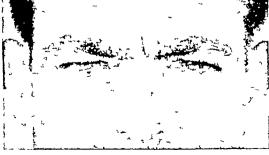


Fig 2 Before and after excision of basal cell epithelioma of lower eyelid and simple closure of defect. A centrally placed lid adhesion was used for three months to prevent ectropion.

must be freely mobilized so that it can be anchored in proper position without tension. One should not hesitate to remove bone that is displaced forward and laterally (Fig. 3). At times the skin incision and closure should take the form of a "Z-plasty" or interposition of flaps so that a flap of skin from the nasal portion of the upper eyelid with base nasal is placed below the elevated canthus (Fig. 4)

A vertical scar of the entire thickness of an eyelid with accompanying notch deformity of the margin, as well as small tumors involving the skin and tarsus, is best excised by vertical parallel incisions through the entire thickness of the eyelid with closure of the defect by Wheeler's "halving" repair ¹ If necessary, the tension at the site of closure can be lessened by means of lateral canthotomy and cutting of the tarsal attachment to the ligament. This can be elaborated to replace a full thickness loss of more than one-third of the eyelid by carrying incisions temporalward to produce a long sliding flap of the Celsus type. This is especially useful in older





Fig 3 (Top) Forward and lateral displacement of right medial canthal area from fracture of frontal process of maxilla, together with loss of right eye incurred in a jeep accident

(Bottom) Deformity corrected by excision of scar tissue, tear sac, and displaced bone in the area, and reattachment of medial canthal ligament to periosteum





Fig 4 (Top) Deformity of medial cauthus and chronic dacryocystitis from fracture repaired by excision of tear sac through a \(\sigma_{\text{shaped}} \) moision with interposition of canthal angle with a flap of sku from nasal end of upper cyclid. This was followed in one month by a small medial canthotomy (Bottom) Final result three months later

adults who do not show the resulting linear scars lateral to the eyelid area. These procedures were well reviewed by Reese several years ago ²

There is no question in my mind and I believe most ophthalmic surgeons agree that Wheeler s method of correcting cicatricial ectropion or lagophthalmos by the use of free skin grafts and lid adhesions is unsurpassed. No other method gives as uniformly satisfactory results Almost without exception there is no place for the use of pedicle flaps or Gillle's "epithelial outlay" for the correction of this condition. The unsatisfactory result obtained by the latter procedure to correct a mild ectropion of the upper cyclids is well illustrated in Fig. 5.



Fig. 5 Additional deformity of upper cyclids produced by cpithelial outlay type of operation for mild ectropion

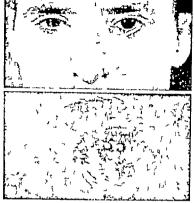


Fig. 6 Before and after repair of moderate creatrical extropion of lower eyelid by full thickness graft from upper cyclid together with central 5 mm. tarsornhaphy (lid adhesion) The lid adhesion was cut three months after skin grafting.

A brief review of Wheeler's method is as follows. The skin incision is made about 5 mm. from the lid margin and parallel to it. Badly scarred skin should be excised Subcutaneous scar tissue must be excised thoroughly to release the lid margin and to provide a good bed for the graft.

Two lid adhesions are usually sufficient at the junction of the middle third of the margin with the lateral and medial thirds. These are prepared by denuding the thin skin from 4 mm rectangles of the lid margin, back of the eyelash line. The superficial tissues are split slightly from the tarsus in these areas and the corresponding 2 areas of each lid approximated by mattress sutures tied through small rectangles of rubber. Upper cyclid akin is by far the best akin to use for the graft. Skin from the cephaloauricular angle is second choice.

The graft need be only slightly larger than the skin defect to be filled. All subcutaneous tissue should be trimmed carefully from the under surface of the graft which is then sutured in place with fine interrupted silk, avoiding trauma to the graft. Perforated cilkloid or some similar smooth material should be placed over the graft and an evenly distributed pressure dressing applied. This should not be removed for six days at which time the hid adhesion sutures are removed and another pressure dressing applied for four to five more days. The lid adhesions should remain about three months. The constant pull of the





Fig 7 Use of posterior auricular skin as a graft for severe cicatricial ectropion of the right eyelids and lagophthalmos on the left Top is appearance before operation, one year after the second and third degree burns of the face Bottom illustrates ability to close eyes well several months after grafts to all lids

opposing eyelid helps the graft to obtain its original size and texture

The correction of cicatricial ectropion by Wheeler's method was done by using upper eyelid skin, posterior auricular skin, and supraclavicular skin, respectively (Figs 6, 7, 8) Wheeler preferred a thin Thiersch or epidermal graft when upper eyelid or posterior auricular skin was not available

For subtotal or total loss of the full thickness of an eyelid, the Hughes method of reconstruction is usually to be preferred 'Pedicle flaps from the forehead or other areas surrounding the orbit should not be used A thick, unsatisfactory eyelid is obtained from a forehead flap, which also produces additional disfigurement to the forehead (Fig 9) The Hughes procedure gives the best results when not much more than the tarsal portion of the eyelid is missing (Figs 10, 11) It is also fairly satisfactory when the loss extends to the orbital margin—In the latter type of case, additional skin can be obtained as a free graft from an upper eyelid—In extensive loss of the





Fig. 8 (Top) Three weeks after supraclavicular skin grafts to lower eyelids for ectropion Lid adhesions will prevent contracture of grafts

(Bottom) Six months later, three months after lid adhesions were cut, the grafts are about same size as originally Note that supraclavicular skin is a bit light in color for eyelids

lower eyelid area, it may be necessary to elevate the skin of the infra-orbital area by means of horizontal sliding flaps (Fig 12) before proceeding with Hughes method of reconstruction

I have found the most satisfactory source of an eyelash graft to be a 3 mm strip from the midportion of the nasal half of the eyebrow rather than the lower margin of the eyebrow as proposed by Wheeler ¹ An eyelash graft for the lower eyelid should be taken from the opposite eyebrow and reversed in direction. If there has



Fig 9 Poor result obtained in reconstruction of middle half of upper eyelid using pedicle flap from forehead with previously placed Thiersch graft as lining on conjunctival surface. Above photograph was taken one year after the surgical repair. Note thick eyelid produced and additional deformity to forehead.

been a loss of lower orbital margin, as well as the lower eyelid, this should be corrected while the eyelids are still joined together. For small losses fascia lata filling is sufficient. For larger losses a bone graft from the ilium gives the most antisfactory results. Most of the cortex is removed from the graft and the cancellous bone is easily shaped The graft should be anchored at either end to the intact bone by fine wire sutures to prevent displacement from the pressure dressing It is usually advisable to use a small rubber tissue drain for a few days, because of the tendency for some clot to collect around the graft. These grafts develop a blood supply rapidly and grow firmly to the surrounding bone in a few weeks. The evelids should not be separated until the external and orbital margin reconstruction are completed

For seventh nerve paralysis which may recover, a simple lateral tarsorrhaphy, or lid adhesion should be used for protection of the eye, or, if accompanied by anophthalmos, 2 lid adhesions should be used to give support to the lower eyelid





Fig 10 (Top) Loss of left eye and approximately half of tarsal portion of upper cyclid from a richocheted bullet. Had had small Thierson graft to assal portion of upper cyclid before evacuation from overseas

(Bottom) Has had Hughes type reconstruction of upper cyclid utilizing small portion of tarsus dower cyclid, and cyclash graft as free graft from cyclrow Most of the Thiersch graft was replaced by full thickness akin graft from opposite upper cyclid.

until orbicularis function returns For permanent seventh nerve paralysis Wheeler had a fairly satisfactory procedure which consisted of a 5 or 6 mm. lateral canthoplasty with a liberal transplant of the lateral ligament more tempor ally with excision of a vertical semilunar piece of excess skin lateral to the canthus.

For a relaxed lower cyclid, which has resulted from facial paralysis or from years of wearing a large proethesis in a socket that has had no im plant, the Kuhnt-Szymanowski procedure for senile extromon is very useful

Lyebrow deformities can often be corrected through the use of a Z-shaped incision and inter-







Fig. 11 (Top) Basal cell epithelioma of lateral two-thirds of left lower cyclid involving chiefly the tarsus.

(Middle) Appearance two months after excision of lateral three-fourths of lower cyclid and first-stage Hughes repair No skin graft required.

(Bottom) Final result. Has had eyelash graft from opposite cyebrow New cyclid fissure was cut five months after initial operation Photograph taken one month later







Fig 12 (Top) Loss of entire lower eyelid area including lower orbital margin and portion of malar eminence. Had had surgical evisceration of eyeball at time of initial debridement two months before above photograph

(Middle) Appearance eight months later Initial operation consisted of excision of broad linear scars, using a large sliding flap of skin and subcutaneous tissue from the temporal side, together with a smaller one from the nasal side. This elevated the tissues so that a first-stage Hughes repair could be done three months later. This was followed by a free skin graft from the upper evelid and later an eyelash graft.

(Bottom) Final result Has had iliac bone graft to lower orbital margin, wedge acrylic implant to floor of orbit, and fascia lata filling graft below eyebrow

position of flaps (Fig 13) Loss of eyebrow is best replaced by a 7 mm free graft from the occipital scalp As with other free grafts, a bed which is free from scar tissue is important About 50 per cent of these grafts give a good regrowth of hair Possibly as many as 25 per cent are not successful at all

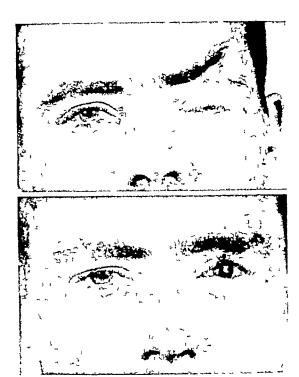


Fig 13 (Top) Left anophthalmos, loss of portion of supraorbital ridge, and deformity of eyebrow resulting from shell fragment wound

(Bottom) Has had eyebrow deformity corrected by Z-shaped incision and simple interposition of flaps. Has also had iliac bone graft to supraorbital area and mucous membrane graft to enlarge eye socket. Appearance would be further improved by fascia lata filling graft below eyebrow

During the past war a high percentage of enucleations and eviscerations were performed without implant This was often probably due to the lack of implants or to the maceration of the The marked retraction of most of these sockets made the fitting of a satisfactory eye unsatisfactory Because prosthesis of marked retraction of the upper portion of the socket, even a large prosthesis does not eliminate the sunken appearance below the eyebrow When this is the result of a simple enucleation a "late" implant is indicated At times Tenon's capsule can be reopened, and an ordinary 16 mm gold or glass sphere can be used with good overlapping closure of Tenon's capsule being obtained Rather than use a smaller sphere, I would prefer to use a grooved glass sphere in the muscle cone in order to obtain more filling It is important that the grooves be deep Many of the so-called Wheeler spheres on the market have such shallow grooves that they no longer serve their purpose

In cases of simple evisceration an implant to the floor of the orbit will usually elevate the orbital tissues sufficiently to eliminate the retraction of the tissues below the brow I find that a wedge-shaped piece of acrylic is satisfactory for



4 The combination of Thiersch graft in a socket with normal conjunctiva

When there has been extensive loss of tissue so that the best result one could hope for would be immobile, unnatural eyelids with a staring conspicuous artificial eye, it is certainly better judgment to remove the remains of conjunctiva and lacrimal gland and to cover the orbit with a continuous layer of smooth skin

144 Harrison Street

Discussion

A. G DeVoe, M.D., New York City —Although this past war has witnessed a rapid growth in plastic surgery as a specialty field, I think that Dr Sherman will agree that, with the possible exception of various acrylic devices, few new technics have evolved in ophthalmic plastic work. We still find the basic principles of Dr John Wheeler as serviceable as ever Whenever I, personally, have deviated from these procedures, I have usually regretted it

There are a few points, however, on which we might take issue, as Dr Sherman has intimated First of all, Dr Wheeler is reputed to have stated that "there are no emergencies in ophthalmology" This, of course, was intended to stimulate thoughtful consideration of each problem rather than hurried operation, but it sometimes has been taken to mean that a lacerated hid incurred at night or on a weekend can wait with impunity for the convenience of the surgeon. It is, of course, true that the relatively high vascularity of tissues about the face may permit satisfactory repair in spite of such delay ever, there can be no question but that the patient's best interests are served when repair work is as early as is compatible with good technic pending the acquistion of proper operating room facilities, suture material, and instruments is to be preferred to hasty operation with inadequate materrals and personnel. Uncontrollable hemorrhage. the only real emergency, is seldom encountered with ophthalmic problems

Another point upon which we might differ with Dr Wheeler's teachings is in the matter of using skin sutures for tension sutures. In this we have much to learn from the general plastic surgeons. They have long since learned that better looking scars as well as a decreased tendency to lose flaps follows the use of fine buried sutures for subcutaneous closure. When this is done, skin closure can be effected with

silk and the sutures removed in forty-eight hours With reasonable success ophthalmologists have been able to omit tension sutures for several reasons, first, because we deal with relatively small flaps. In the second place, in no other part of the body can pressure dressings be applied so effectively, and, lastly, the vascularity of periorbital tissues makes healing in this region more certain than in many other localities. Nonetheless, I feel that we can improve the quality of our work by making greater use of separate tension sutures.

Dr Sherman's plea to make repairs as simply as possible and to use eyelid tissue to repair eyelid defects whenever possible bears re-emphasis. All of the textbooks show complicated forehead flaps. tubed pedicle grafts, and other more or less mutilating procedures which rarely can be justified about the eye Certainly, there are occasions when marked loss of structure will require a tubed pedicle, formed from the neck or elsewhere, but in these cases the damage is so extensive that the chief aim is not protection of the eyeball or restoration of ocular function but simply that of providing skin covering to a denuded area without hope of approaching cosmetic perfection Few ophthalmic surgeons will find the opportunity to acquire the necessary experience in handling tube pedicles, and no doubt these cases will be referred to general plastic sur-The desirability of cooperation with general plastic surgeons needs no elaboration, although much remains to be accomplished in this field.

Finally, we might as well admit that there are patients who will be so little improved as far as the gross cosmetic effect is concerned that operation is hardly justified. Years of repeated operations, while of technical interest to the surgeon, may eventuate in thick motionless lids and a dry lustreless prosthesis which are more disfiguring than a simple black patch.

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FULL-SCALE CHECK-UPS FOR SCHOOL CHILDREN

Instead of a routine once-over, New Jersey school children will henceforth get a thorough physical examination, including psychiatric observation, at regular intervals. The new plan has been worked out by the New Jersey Medical Society and the state

department of health Each child will be examined, in the presence of a parent, at least four times during his grade school years Teachers will undergo a chest x-ray each year — Medical Economics, January, 1948

SOME OBSERVATIONS ON THE NEUROGENIC BLADDER

WILLET F WHITMORE, M.D., and LUIS M ISALES, M.D., New York City

(From the Veterans Administration Hospital, Bronx)*

AMONG the casualties of World War II are roughly 2,000 men who sustained spinal cord or cauda equina injuries. The literature contains many fine articles on all phases of the most noteworthy contributions have been made by urologasts

The present communication is based on experience at the Veterans Administration Hospital Bronx, New York, with patients who sustained spinal cord or cauda equina injuries during the past war The urologic management of the so-called neurogenic bladder has been amply discussed by others and is not considered further in this paper.

The subject has been approached by correlating the neurologic level of the lesion and the physical completeness or incompleteness of the lesion with the mechanism and adequacy of bladder emptying. The influence of the general condition of the patient and of the past history of suprapublic cystostomy drainage on the mechanism and adequacy of micturition has also been considered.

In characterising the level of the particular lesion, the neurologic level has been employed Lesions are considered physiologically complete if there is loss of sensibility and loss of voluntary motor function below that level, whether or not actual anatomic interruption has been demon strated at laminectomy

The general condition of the patient has been characterized as excellent, good, fair, or poor, depending on the over-all state of health at the time the observations were made, irrespective of the past history

In grouping the patients according to the mechanism of micturation, the classification of neurogenic bladders, as proposed by McLellan, has been employed with only slight modifications. The patient has been placed in that classification which most accurately illustrates and explains the manner in which he voids clinically. Cystometric studies have been employed to aid in such classification when necessary

In grouping and comparing patients, it has been necessary to set up some admittedly arintrary standards, the advantages and limitations of which need no explanations. Likewise, the use of a rather rigidly defined classification in grouping the neurogenic bladders must not be construed as denying the existence of a wide overlap between adjacent groups. Lastly, the necessity for brevity and generalization has made inevitable the omission of many, frequently important details

In a series of 109 patients with spinal cord or cauda equina injuries, observations have been sufficiently complete to warrant inclusion in this study of 90 instances. In the great majority of these patients it has been at least two years since the injury was sustained, in no case has the clapsed time been less than six months

Table I outlines the classification of neurogenic bladders and shows the absolute number, as well as the percentage distribution, of the 90 cases in the different groups. It will be noted that normal bladders and unnhibited reflex neurogenic bladders were quite uncommon and that no truly atonic bladder was present in this series. The reflex neurogenic bladder was by far the most common and was twice as frequent as the autonomous type.

Each type of bladder will be considered in turn

TABLE 1.—Classification of Nausogemic Bladders
Showing Distribution of Patterns

Type of Neurogania Bladder	Number of	Percentage of
Bladder	Cases	Percentage of Total Cases
Normal	2	2 3
Uninhibited reflex Reflex	5	5 6
Normal	48	53 8
Hypertonie	7	7 8
Antonomous	28	81 1
Atonio	0	0
	90	100

Normal Bladder

As a working theory of normal micturition, Munro's formulation, slightly modified, has been employed 1.3

Micturiton is a reflex act, normally under voluntary control the reflex centers lying in the sacral segments of the spinal cord. Micturition is the result of reflex contraction of the detrusor muscle, followed by reflex relaxation of the internal sphineter, followed by reflex relaxation of the external sphineter. The stimulus for detrusor contraction is the result of bladder filling with resultant stretching of the smooth muscle fibers of the bladder wall, both afferent and efferent ares of this reflex travelling via the parasympathetic nerves. Detrusor contraction causes internal

^{*} The opinions expressed in this paper are those of the authors and do not necessarily reflect those of the Veterans Administration.

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sphincter relaxation reflexly Relaxation of the external sphincter follows internal sphincter relaxation and seems to be reflexly related to detrusor contraction and/or internal sphincter relaxation. It is apparent that the potentialities for bladder emptying he within the sacral segments of the spinal cord.

Suprasegmental control provides inhibitory influences on the sacral centers which prevent automatic evacuation of the bladder with the first impulses of smooth muscle stretch vesical distention proceeds further before reaching the level of consciousness or before the urgency of reflex detrusor contraction necessitates emptying Voluntary contraction of the external sphincter at this point results in still greater storage of Facilitation of micturition is attained only by the control of inhibitory impulses from the higher centers, that is, one cannot will an emptying contraction, one can only suppress the inhibitory impulses, thus permitting the reflex act Relaxation of the external sphincter can only occur reflexly

In the normal individual, micturition is under voluntary control. The urinary stream, once started, can be maintained with good force and without straining until the bladder is empty. Contraction of the external sphincter will cause prompt cessation of the urinary stream during any phase of micturition and will also result in reflex inhibition of the detrusor contraction. The average adult voids about 300 cc. of urine at a time.

In only 2 of the 90 patients studied did a normal type of micturation eventuate. One of these patients had an incomplete traumatic cauda equina injury involving the first and second sacral segments on the left. The other had a myelomalacia of the conus medullaris with incomplete involvement of the twelfth thoracic through the fifth sacral segment.

Uninhibited Reflex Neurogenic Bladder

In this type of bladder there is partial interruption of the pathways connecting the reflex centers in the sacral cord with the center or centers for cerebral control As a result the inhibitory effect of cerebral control over the lower centers is lost Although sensation may be normal and voluntary external sphincter control intact, these patients exhibit urgency and occasional imperative or precipitate micturition This urgency is the result of uninhibited detrusor contraction in response to bladder filling By voluntary contraction of the external sphincter, micturition may be held in abeyance and the detrusor contraction caused to subside reflexly Bladder capacity is usually mildly reduced, and residual urine is absent

Five of the 90 patients studied fell into this group. The neurologic levels in these patients showed wide variation, but in all instances the lesions were grossly incomplete.

Reflex Neurogenic Bladder

With this type of bladder the reflex centers for micturition in the sacral cord are intact, as are the afferent and efferent sides of the reflex arc, but there is interruption of the pathways connecting the reflex centers with the higher controls. As a result, bladder emptying occurs automatically when the afferent impulses from the stretching smooth muscle fibers of the bladder reach sufficient intensity to cause a reflex discharge of impulses over the efferent side of the arc. Since the cerebral fibers concerned with voluntary control of the external sphincter are also severed, micturition is entirely involuntary.

Clinically, the reflex neurogenic bladders can be divided into the normal reflex and the hypertonic reflex types

The normal reflex neurogenic bladder has a capacity ranging from 150 cc to 750 cc, and there may or may not be residual urine. Clinically, these patients void at widely varying intervals and in widely varying amounts. Urination is usually precipitate. The urinary stream is quite variable but is frequently forceful. The bladder is frequently emptied by a series of closely successive voidings of gradually diminishing volume.

The hypertonic reflex neurogenic bladder has a capacity less than 150 cc. The patients in this group void small amounts at frequent intervals Residual urine is usually small in amount or absent

In neither type is voiding associated with abdominal straining

The patients with reflex neurogenic bladders have no direct voluntary control over the external sphincter. In some patients, however, the external sphincter may contract as a part of the skeletal muscle response, frequently occurring below the level of the lesion as a result of a suitable stimulus. This contraction of the external sphincter is sufficient to cause interruption of the urinary stream.

Facilitation of micturition by means of stimuli, most effectively applied to areas of sacral nerve sensory distribution, is also frequently observed. This permits a degree of voluntary control in the initiation of micturition.

It is in this group of patients with reflex neurogenic bladders that vesical contraction may occur as part of the so-called mass reflex. In these instances there is a latent period between the skeletal muscle response to the inciting stimulus and the onset of micturition. This is probably due not only to the longer latent period between stimulus and response in smooth muscle but to the mechanically, as well as reflexly, inhibitory effect of the external sphineter contraction which accompanies the skeletal muscle response.

The group of reflex neurogenic bladders can be further grouped as satisfactory or unsatisfactory on the basis of the efficiency of micturition. By the arbitrary standards employed here, a satisfactory bladder is defined as one which voids 100 ec or more at a time with a residual urine volume of 100 ec. or less.

Of 55 patients with reflex neurogenic bladders 48 (87.3 per cent) were the normal reflex type and 7 (12 7 per cent) the hypertonic reflex type

In analyzing this group of patients it is noted that the so-called automatic bladder can develop in the presence of physiologically complete or in complete neurologic lesions occurring apparently at any level of the spinal cord. In addition, an automatic bladder can develop in the presence of cauda equina injury, provided the injury is incomplete.

Of the 48 patients with normal reflex bladders 25 (521 per cent) were satisfactory and 23 (479 per cent) unsatisfactory according to the arbitrary standard employed. An attempt has been made to show the relation of the neurologic level and physiologic completeness of the lesion to the occurrence of a satisfactory or unsatisfactory bladder (Table 2)

TABLE 2.—Relation of Neurologic Level and Presiologic Completeness of Lesion to Occurrence of Satisfactory Normal Replex Neurogenic Bladder

	Satis	factory	Uneat	lafactory	Total
Neurologic Level of Lexion	Com plete	Incom-	Com-	Incom plete	Number of Cases
Cervical Upper thoracle	1	3	0	1	5
Upper thoracle T1-T4 Middle thoracle	4	4	5	2	15
LOWET thorneis		2	7	2	16
T10-T10	3	1	1	1	6
Canda equina	0	2	0	4	6
Total	13	12	13	10	48

Although the number of cases is small from the statistical standpoint, one is impressed by the wide distribution of satisfactory and unsatisfactory bladders, irrespective of the neurologic level and the physiologic completeness or incompleteness of the lesion

TABLE 3.—RELATION OF OCCURRENCE OF SATISFACTORY NORMAL REFLEX NEUROCEPIC BLADDER TO DURATION OF SUPPAPORISE CHETOPOTOMY

D ration of Suprapuble Cyntostomy	Satisfactory 15	Unextisfactory 8
6 months or less 6-12 months	Ž	1
12-18 months 18-24 months	1	2
24-35 months More than 30 months	<u>i</u>	
Total	25	23

A further analysis of the satisfactory and unsatisfactory bladders has been made, first, with reference to the duration of the suprapulse cystostomy and, second, with reference to the general condition of the patient (Tables 3 and 4) There is a fairly distinct tendency for the duration of suprapuble cystostomy to be shorter in the satisfactory than in the unsatisfactory bladders. The average duration of the suprapubic cystostomy was seven months in the antisfactory cases and almost eleven months in the unsatisfactory cases.

No definite statement can be made regarding the importance of the general condition of the patient to the existence of a satisfactory or unsatisfactory bladder

TABLE 4—RELATION OF COCURRENCE OF SATISFACTORY NORMAL REFLEX NEUROGENIC BLADDER TO GENERAL CONDITION OF THE PATIENT

General Condition	Satisfactory	Unsatisfactory
Excellent	9	3
Good	ğ	13
Fair	5	7
Poor	2	1
	_	
Total	25	23

There were 7 patients in the reflex neurogenic group who were classified as having hypertonic reflex bladders. Although this is too small a number to have any statistical significance, an analysis of these patients was carried out as a matter of interest. Of these 7 patients, 5 had un satisfactory and 2 had satisfactory bladders (Table 5)

TABLE 5—RELATION OF NEUROLOGIC LEVEL AND PHYSIC LOGIC COMPLETENESS OF LESION TO OCCURRENCE OF SATISFACTORY HYPERONIC RELEAN NEUROLOGIC BLADDEN FACTORY HYPERONIC RELEAN NEUROLOGIC BLADDEN

Neurol gie Level of Lerion		otory Incom- plete	Com-	factory Incom plete	Total Number of Cases
Cervical Upper thoracle	0	0	0	1	1
Ti-T4 Middle thoracia	0	0	1	0	1
T4 T9	2	0	1	0	3
Ti0-Ti2 Cauda equina	0	0	1 0	0	1
Total	2	0	3	2	7

Hypertonic reflex bladders occurred over a wide range of neurologic levels of injury of the spinal cord with one incomplete lesion of the cauda equina. Further analysis of this small group did not seem justified. It is notable however that the average duration of suprapublic cystostomy in the group was almost eighteen months and that with only one exception all of the patients were in good condition

Autonomous Neurogenic Bladder

With this type of bladder there is interruption of both afferent and efferent sides of the bladder

reflex arc The bladder activity which remains is believed to be due to innervation supplied by ganglia in the vesical wall

Clinically there may be complete retention with overflow incontinence or feeble and inefficient contractions, resulting in a loss of only a few cubic centimeters of urine at a time. There is no true voluntary control. Voiding may be aided by abdominal straining or by the use of Credé pressure. There is usually residual urine. Bladder capacity approximates normal.

Twenty-eight of the patients studied were grouped as having this type of bladder. Only 7 (25 per cent) were satisfactory, the remaining 21 (75 per cent) being unsatisfactory (Table 6)

TABLE 6 —RELATION OF NEUROLOGIC LEVEL AND PHYSIC-LOGIC COMPLETENESS OF LESION TO OCCURRENCE OF SATIS-FACTORY AUTONOMOUS NEUROGENIC BLADDER

	Satisi	actory		factory	Total
Neurologic Level of Lesion	Com plete	Incom- plete	Com- plete	Incom plete	Number Cases
Cervical	0	0	0	2	2
Upper thoracio • T1-T4	0	0	3	0	3
Middle thoracic	0	0	3	2	5
Lower thoracio T10-T12 Cauda equina	1	- 0	1 5	0 5	2 16
Total	<u> </u>	6	12	9	28

It will be noted that cauda equina injuries were the most common lesions associated with the autonomous bladder. This is implicit in the definition of this type of bladder. In the cases not specifically labelled as cauda equina injuries, the lesion was frequently an extensive one destroying the major portion of the spinal cord from the specified level of the lesion downward

Aside from the frequent occurrence of autonomous type bladders with cauda equina lesions, the most noteworthy finding was the fact that in the present series no instance of a satisfactory autonomous bladder with a complete cauda equina injury was recorded

TABLE 7—Relation of Occurrence of Satisfactory Autonomous Neurogenic Bladder to Duration of Suprapubic Cystostomy

Duration of Suprapubic Cystostomy	Satisfactory	Unsatisfactory			
0	4	8			
6 months or less	8	Ō			
6-12 months	0	8			
12-18 months	0	7			
18-24 months	0	1			
24-36 months	0	2			
More than 36 months	0	0			

The relation of the occurrence of a satisfactory bladder to the duration of suprapubic cystostomy is shown in Table 7—The duration of the suprapubic cystostomy averaged one and three-tenths months in the satisfactory autonomous bladders and eleven months in the unsatisfactory autonomous bladders. Of the satisfactory cases none had a suprapubic cystostomy longer than six

months, while in the unsatisfactory cases 13 cases had such drainage for more than six months. No significance can be attached to the results of relating the occurrence of the satisfactory autonomous bladder to the general condition of the patient (Table 8)

TABLE 8—Relation of Occurrence of Satisfactory Autonomous Neurogenic Bladder to General Condition of the Patient

		
General Condition	Satisfactory	Unsatisfactory
Excellent	2	2
Good	4	14
Fair	1	3
Poor	0	2
Total	7	21

Atonic Neurogenic Bladder

This type of bladder is seen during the stage of so-called spinal shock, following severe spinal cord or cauda equina injury

Clinically, the bladder capacity is large, and there is usually a large residual volume. Voiding is accomplished by increasing intra-abdominal pressure by straining or by the use of Credé pressure. Continued straining is necessary for maintenance of the stream, which is weak and dribbling. There is frequently retention with over-flow incontinence.

In none of the group of patients studied in this series was this type of bladder encountered

It has been recognized for many years that during recovery from a severe spinal cord or cauda equina injury the bladder frequently passes successively through atonic, autonomous, hypertonic reflex, normal reflex, and uninhibited reflex phases in reaching its previous normal condition Depending upon the nature of the injury and other factors, recovery may stop at any of these phases

In the present group of cases the end stage of bladder recovery had apparently been reached in all but a few cases when these patients were first studied at this hospital. Accordingly, it is understandable why no atonic bladders were seen. In many instances, however, it has been possible by careful questioning to elicit a history of, at least, an atonic-like bladder during the period immediately following the injury.

In some of the patients who were classified in the group of autonomous neurogenic bladders, the bladder capacities were larger and the corresponding intravesical pressures lower (as determined by cystometric studies) than is usual for the typical autonomous type. However, the intravesical pressure curves were always considerably higher than those obtained with a typical atonic bladder, and this was the reason for placing them in the autonomous group

Table 9 relates the incidence of the different types of neurogenic bladders to the total number

of lesions occurring at the different neurologic levels. Soveral facts are evident

- 1 Thoracic cord mjunes made up 61 1 per cent, cauda equina injunes 28 9 per cent, and cervical cord injuries only 10 per cent of the total series of 90 cases.
- Normal reflex neurogenic bladders developed in more than half of the cases of spinal cord injury, no matter what the neurologic level. but in less than one fourth of the patients with cauda equina lesions. Of the patients who developed normal reflex neurogenic bladders, function was satisfactory in about one half of the cases. No striking difference in the incidence of normal reflex neurogenic bladders at any par ticular neurologie level was demonstrated, al though the incidence was highest (71 5 per cent) in the upper thoracic lesions Further analysis of the normal reflex bladders into satisfactory and unsatisfactory groups relating to each neurologic level, gave series too small to be statistically sig nificant, although these figures are included in the table

3 The group of hypertonic reflex neurogenic bladders is very small, but the highest inoidence was noted in the middle (12 5 per cent) and lower thoracia (10 per cent) lesions

4 The incidence of autonomous neurogene bladders, as would be expected, was highest in the cauda equina lesions (61.5 per cent), but was present in from 14 3 per cent to 22.2 per cent of spinal cord injuries as well

5. In the entire series of 90 cases 45 6 per cent of the patients developed satisfactory vesteal function, while function was considered unsatisfactory in 54 4 per cent

Discussion

It would be unwise to conclude this paper with out some further acknowledgment of the limitations of the present data. It seems almost unnecessary to point out that it is impossible to characterise accurately a spinal cord or cauda equina injury merely by giving the highest recognizable segmental level of nervous damage and by stating whether or not the lesion is complete. In order to do full justice to this most important factor, it would be necessary to reproduce in its entirety the neurosurgical examination on each patient. This is manifestly impossible, and a very busy method of representation has had to suffice.

The duration of suprapubic cystostomy was chosen for consideration as a factor in the development of a satisfactory bladder, chiefly because it has been something of a bone of contention between urologists and neurosurgeons in the management of the neurogenic bladder The data here presented would, at face value, tend to support the neurosurgical view that suprapubic

Nectrologie		Toinhibite	N.	Type of	Type of Nourogenie Bladder	50			F	1
Level of Leadon	Normal	Refer	Satisfactory Unsatisfie	otory	Sathfactory	Unsatisfactory	Satisfactory Unsatie	Satisfactory Unatisfactory	Satisfactory Unestiafact	Unestiafactory
	0	1 (L.1 per cent)	6 (33.5 per cent)	-	1 (1.1		. (22.3 Per east)		per eent)	per cent)
oper thoracle					0				10 (47 6 010 per cent)	eent) 11 (52.5
	0	2 (9.5 per cent)	15 (71.5 per 0ent)		1 (4.6 Der cent)		3 (14.3 per cent)		per cent)	per cent)
fiddle thoracle				•			0	10	0 (37 5 13.3 per cent)	r cent) 5 (62.5
;	0	•	16 (00.7 Per cent)		2 (12.5 per cent)		5 (20.8 per cent)		per cent)	per cent)
Ower thornole T10-T13	1 (10 per cent) 0	•	d (60 per cent)	н	0 1 (10 per cent)		1 2 (20 per cent)		\$4 (26.7 per cent) 6 (60 per cent) 4 (40 per cent)	r cent) 4 (40 per cent)
ands equins			~	·	1 0			10	11 (42.3 (11 1 per cent)	r cent) J5 (57 7
	1 (3.8 per cent)	2 (7 7 per cent)	6 (23.1 per cent		1 (3.6 per cent)		16 (61.5 per cent)		26 (28.9 pe	26 (28.9 per cent)
Total	2 (2.2 per cent)	6 (f.6 per cent)	25 (52.1 23 (47.9 per	23 (47.9 per cent)	3 (28.6 5 (71.4 per cent)	5 (71.4 per cent)	7 (25 per cent)	7 (25 per cent) 21 (75 per cent) 41 (45.6 per) GE	49 (54.4 per cent)
		,		per cent)	7 (7.8 per e	fat)	(())	(100)		ţ

cystostomy has a deleterious effect on the ultimate development of a satisfactory neurogenic bladder It would be unfair, however, not to point out that such relatively indeterminate factors as the quality of nursing and medical care, the amount of urmary infection, and the general state of nutrition of the patient from the time of injury to the time of these observations are possibly and probably of equal importance Other factors. such as the presence of multiple decubitus ulcers and the existence of contracture deformities and muscle spasm, also play an important role in bladder recovery

The general condition of the patient at the time of the observations has been disappointing in prognosticating the occurrence of a satisfactory or unsatisfactory bladder. In the few instances where the relation between the excellent condition of the patient and the occurrence of a satisfactory bladder was apparent, one might wonder justly whether the excellent condition of the patient was the cause or the effect of the satisfactory bladder

It is noteworthy that more than half of the group of normal reflex neurogenic bladders developed bladder function, which was considered satisfactory by the arbitrary standards employed, without the necessity for transurethral resection

Finally, a word about the value of transurethral resection of the vesical neck in the treatment of the neurogenic bladder The operation has been performed on 18 patients who had unsatisfactory normal reflex neurogenic bladders and on 7 patients who had unsatisfactory autonomous neurogenic bladders. In the normal refler neurogenic bladders 8 (44 4 per cent) of the 18 patients developed satisfactory bladders following the operation, while 10 (55 6 per cent) remained unsatisfactory Of the 8 satisfactory results, 2 required 3 resections, one required 2 resections, and the remaining 5 patients required only a single resection each Of the 10 failures, 4 had 2 resections and 6 had only 1 In the unsatisfactory autonomous neurogenic bladders, transurethral resection was followed by the development of a satisfactory bladder in 6 (85 7 per cent) of the 7 cases in which it was performed Of the 6 satisfactory results none required more than 1 resection, and the single unsatisfactory result has had 2 resections without benefit In classifying the different types of neurogenic bladders as satisfactory or unsatisfactory in the foregoing sections. of this paper, the condition of the bladder prior to transurethral resection has been the basis for such classification

Summary and Conclusions

An analysis of vesical motor function has been made in a group of 90 patients with spinal cord and cauda equina injuries Ten per cent had cervical cord lesions, 61 1 per cent thoracic cord lesions, and 28 9 per cent cauda equina lesions

- Of these 90 patients 2 2 per cent developed normal bladders, and 5 6 per cent developed uninhibited reflex neurogenic bladders. These were in every instance associated with grossly incomplete neurologic lesions and were considered satisfactory by the arbitrary standard employed
- Except for the normal and uninhibited reflex neurogenic bladders, the physiologic completeness of the neurologic lesion had no decisive influence on the type of neurogenic bladder that developed However, no complete cauda equina lesion was associated with a reflex neurogenic bladder, nor did any patient with a complete cauda equina lesion have satisfactory vesical function
- Normal reflex neurogenic bladders made up 53 3 per cent of the 90 cases More than half of all patients with spinal cord injuries, irrespective of the neurologic level, developed this type of bladder, but less than one fourth of patients with cauda equina injuries did so About half of the normal reflex neurogenic bladders were considered satisfactory by the standard employed

Only 78 per cent of the 90 cases developed a hypertonic type of reflex neurogenic bladder The incidence was highest in the middle thoracic and lower thoracic neurologic levels

Autonomous neurogenic bladders made up 31.1 per cent of the 90 cases The incidence was highest (61 5 per cent) in patients with cauda equina injuries but varied from 143 to 222 per cent in spinal cord injuries, irrespective of the neurologic level

Of the 90 patients 45 6 per cent developed satisfactory bladders, 544 per cent were considered unsatisfactory

The general condition of the patient was not usually of value in prognosticating the presence of a satisfactory bladder

The present analysis tends to confirm the view that suprapubic cystostomy is deleterious to the ultimate development of satisfactory bladder function, but many factors of relatively indeterminate nature are probably of at least equal importance

Transurethral resection of the vesical neck has improved bladder function in 44 4 per cent of the unsatisfactory neurogenic bladders and 85 7 per cent of the unsatisfactory autonomous neurogenic bladders in which it has been employed

Some of the limitations of the present analysis have been pointed out

References

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Symposium

"The Treatment of Bladder Tumors

RESULTS OF RADIATION THERAPY OF BLADDER CANCER

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SINCE there are no spontaneous cures of blad der cancer and since it is a highly fatal discase a trial at therapy is warranted

Radiation therapy in cancer of the bladder has much to recommend it. Some cancers have been found to be radiosensitive and, in actual practice, some vesical cancers have been cured by radiation. The bladder is sufficiently accessible to permit application of an adequate desage to the lesson, and little skill is required to implant radion or radium into the bladder. The immediate mortality is low, the cause of ultimate death rarely being attributed to the treatment. The propor desage of radiation can be determined from published reports on the subject, or the radiologist may prescribe treatment. The patients thus treated do not require long hospitalization.

With so many advantages to this therapy, it seemed worth while to determine the end results obtained. Three hundred consecutive cases, treated for cancer of the bladder between 1932 and 1938, were reviewed Patients with papil loma of the bladder, even when atypical cells were present, were not included in the study. All the cases reported had biopsy proved cancer

The method of treatment followed a general plan. Radon seeds were implanted into the base of the tumor after the bulky mass had been super ficially excised. A radiation was often given to the pelvic region in addition.

Six of the 300 patients were dead of other causes and without evidence of neoplasm at death before five years had elapsed (2 per cent) Three were lost to follow up study (1 per cent) There are, then, 291 determinate cases, of which 232 or 79 7 per cent, are known to have died of the disease, its complications, or treatment Twenty one patients with disease were lost track of and considered failures 11 others survived five years but definitely still with disease Thus 264 or 80.8 per cent, are failures at the time of the five year anniversary of diagnosis. Twenty-seven cases or 9.2 per cent might be called five-year

successful results, but approximately half of these will not stand up under a critical re-examination. The five-year 'curo' rate was, therefore, approximately 6 per cent. Only 52 cases or 17.3 per cent, were known to have survived merely five years.

A comparison of these statistics with life insurance company figures for the general population at the same age as the average of our group and with figures on untreated bladder cancer patients is not very cheerful. A comparison of the graphs of survival of these 3 groups appears even more discouraging, because of the parallelism and proximity of the untreated and radiated groups and also because of their marked variation from the general population.

All this is bad enough, but what of morbidity and palliation? In one group of 102 consecutive cases, 15 per cent required unplanned-for operations upon the upper tracts for acute processes Hydronephrosis with loss of function was not rare At least 2 developed fecal fistulas, and 4 developed vesicovaginal fistulas. The following complica tions were at least not currosities contracted bladder, calcult, incontinence, poorly healing wounds, chronic edema of the genitalia, radiation proctitis, late radiation ulceration of the skin. hemorrhage, etc Finally the vast majority had quite bothersome symptoms from cystitis, which commonly lasted several months, and some of which occasionally never cleared A frequent problem was the determination as to whether or not cancer still persisted beneath the inflamma tion and alough Radiation of metastases often produced temporary relief from pain.

Of 53 autopoles, no metastases were found in 43 4 per cent, but it must be remembered that most patients died elsewhere and that these autopsies are from institutions, where terminal care patients are not routinely admitted. A large number died of damage to the upper tracts rather than cancer per se. In fact, one wonders whether mere protection of the upper tracts would not improve results.

Histologically, low grade cancers showed better

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results than those highly malignant, but only 40 per cent of the patients with grade I and II lesions were known to have survived three or more years

It must be pointed out that these items do not indicate that the treatment rather than the disease caused all this trouble. In fact, one of the advantages of radiation therapy seems to be that good results can be attributed to radiation, while poor results can usually be charged to the disease

However, few indeed were the complications of the disease itself which were avoided by radiation One would suspect that some complications were added or intensified by radiation

In conclusion, our results by radiation methods have been so poor that we feel justified in trying other therapy, in spite of a very small percentage of cures—Perhaps the very nature of the disease will not permit improvement by any means now available

TRANSURETHRAL TREATMENT OF BLADDER TUMORS

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IN THE past several years an increasing number of patients have been treated for bladder neoplasms transurethrally because of improvements in surgical equipment, namely, the prostatic resectoscope The advantages of the resectoscope are many, and anesthesia, preferably spinal, should always be employed The removal of blood clots with the aid of the Ellik evacuator and the Toomey syringe and the control of the bleeding with the resectoscope save many unnecessary cystotomies The positions of the majority of tumors are on the base and on the lateral walls of the bladder and are especially The size of the tumor can adapted to excision be measured by the loop

The number of bladder tumors which can be treated transurethrally is limited by the experience and ability of the operator in the use of the resectoscope A large amount of tissue, including the base of the tumor with muscle and adjacent mucosa, can be removed for histopathologic This allows a more accurate pathologic diagnosis One must always remember that a tumor is just as malignant as its most malignant It is not unusual to see papilloma and low grade carcinoma on the same slide The gross picture of malignancy is rarely mistaken for papilloma, but often an apparent papilloma is malig-Surely, fewer errors will occur when the pathologist is given adequate amounts of tissue To eliminate the possibility of for examination perforating the bladder during a resection, the tumor should not be resected with the bladder overdistended, especially when the base is being removed

Selection of cases for transurethral treatment with the expectation of a cure is made after careful evaluation of the over-all picture, including (1) an intravenous pyelogram which does not show obstruction to the upper urinary tract, (2) absence of any gross infiltration on bimanual examination, (3) cystoscopic examination which reveals single or multiple noninfiltrating papillary lesions of varying size which are located in such a position that they can be reached by the resectoscope loop, and (4) a pathologic report revealing either benign papilloma or papillary carcinoma, grade I, which shows no evidence of infiltration

The basis of this report is formed by 140 consecutive cases, treated transurethrally by fulguration and resection, selected from a group of 313 patients with bladder neoplasms which had received various forms of therapy

Table 1 shows there were 95 benign papillomas (58 were single, and 37 were multiple) In the carcinoma group there were 45 cases (22 single and 23 multiple) In the benign group there was recurrence of the single tumors in 13 cases (22 per cent) and of the multiple tumors in 25 patients In the multiple benign tumor (70 per cent) group 8 patients subsequently showed biopsies which were malignant, six of these were six to twelve years after the original diagnosis longest interval before recurrence was nineteen In the malignant group there was recurrence of the single tumors in 4 cases (18 per cent) and of the multiple tumors in 10 patients (43 per In both groups the recurrence of single tumors was 18 per cent and of the multiple tumors, 58 per cent

TABLE 1 —Number and Types of Bladder Tumor Lesions of Low Grade Malignanot Treated Transurethrally

			
	Single	Multiple	Total
Papilloma Carcinoma	58	37*	95
Carcinoma	22	23	45

^{*} Eight of these cases reported benign subsequently were reported malignant

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Table 2 summarizes the follow up of all cases. In the papilloma group 47 cases were followed less than five years, these cases averaged two and three-tenths years. There was 1 death from other causes.

In the group followed more than five years there were 44 cases with an average follow-up of eleven and two-tenths years. One patient died from carcinoma of the bladder, and 3 died from other causes In the carcinoma group, 30 cases were followed less than five years, the average being two and two-tenths years. One patient died from carcinoma of the bladder, and 4 patients died from other causes. The 13 cases followed more than five years averaged twelve and one-tenth years. There was 1 death from carcinoma of the bladder and 1 from other Causes.

TABLE 2 -FOLLOW UP ON CASES TREATED

	Less than 5 years	More than 5 years	Lost
Papillomes	47	44	4
Average Died of carcinoma	2 S years	11 2 years	-
Died of carcinoma	0	1	
Died of other causes Carcinomes	.1	.3	_
Average	30	14	2
Died of eareinoms	2 2 years	12 1 years	
Died of other causes	÷	i	
market or other charles	•		

Comment

1 It is obvious from the above series that the only type of lesions treated were papillomas (angle and multiple) and nominitrating papillary carcinomas, grade I (single and multiple)

2 This treatment has offered as good a sta tistical result as could be anticipated by any other

method

3 The incidence of recurrence is sufficiently high to warrant the most careful periodic examination, and it is recommended that observation cystoscopy be performed at three-month intervals for the first year, six-month intervals for the next two years, and yearly intervals thereafter. The longest interval before recurrence in this study was nineteen years.

4 It is known that a benign papilloma may undergo malignant change. In the series reported 8 cases of benign papillomas with adequate biopsies were subsequently reported malignant (6 became malignant six to twelve years after the original bloosy)

5 Palliative transurethral treatments of bladder cardinoma have not been included in this

study

6 There were no deaths from the operative procedure

SEGMENTAL RESECTION OF THE BLADDER FOR CANCER

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WHEN bladder tumors are unsuited for locally destructive treatments such as electrocoagulation or interstitial radiation applied either transurethrally or through the opened bladder, resection of the tumor-beam area appears to be the most conservative treatment which offers a reasonable chance of a cure.

The operation, as it is usually performed, con sists of freeing the affected portion of the bladder from its external attachments and resosting that segment, the perivesical fat and pentoneum being included where possible Experience shows that it is of fundamental importance to remove with the tumor a safety zone of apparently normal bladder wall at least 3 cm. wide on all sides of the growth.

The principal advantage of this operation less in removing the entire thickness of the bladder wall so that, conceivably, it is possible to remove infiltratung cancers. In addition, the patient re-

tains his bladder and prostate with this operation One disadvantage of the method lies in its being suited to a relatively small proportion of bladder cancers which must be carefully chosen by methods lacking precision. No examination, for instance, can detect infiltration of cancer cells in the perivesical tissues, and the most careful cystoscopic scrutiny cannot measure the extent of submucous infiltration If all segmental resections were limited to tumors of the bladder vault these hazards would approach an irreducible minimum but, unfortunately, in an effort to preserve a functioning bladder and to avoid more radical surgery, resections remove segments of the lateral walls, trigone, and even portions of the verical outlet. Although a ureter can be reim planted readily in the bladder, few such extensive resections are ultimately successful, because these ill-chosen operations do not remove all of the neoplasm

Since 1932, there have been 30 cases of bladder cancer treated by segmental resection on our serv ice. Private and service cases are included. It is

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realized that from such a small group of cases no significant statistics can be compiled However, completeness of the symposium indicates their inclusion in this presentation

The average age of the 30 patients was fifty-five years Twenty-one, or 70 per cent, were men, the average age being fifty-two years—the youngest being thirty and the oldest, sixty-eight Nine, or 30 per cent, were women, the average age being fifty-eight years—the youngest, thirty-six and the oldest, seventy-one

The average duration of symptoms was two The longest history was nine years, and the shortest, one week.

Symptoms in order or frequency were as follows hematuria, 25, dysuria, 10, frequency, 9, abdominal pain or renal colic, 6, nocturia, 4, urgency, 2, and retention, 1

Hematuria, therefore, was the most common symptom and was the one longest neglected

Six of these 30 patients, or 20 per cent, had been treated previously for periods ranging from four months to four and one-half years before resection was done

The types of tumors found were 3 papillomas, $3 \, \mathrm{grade \, I}$, $15 \, \mathrm{grade \, II}$, $6 \, \mathrm{grade \, III}$, and $2 \, \mathrm{grade \, IV}$ carcinomas One was a sarcoma On comparison of the biopsy and the surgical specimen, 7 surgical specimens showed a higher degree of malignancy than appeared in the cystoscopic biopsy, 7 were of the same degree, and 2 were of a lower grade For various reasons the remaining specimens could not be compared

In March, 1947, 15 of these 30 cases were hving, and 15 were dead Of these 15 dead, 3, or 20 per cent, were surgical mortalities patient with a grade III tumor died four hours postoperatively of pulmonary embolism with a papilloma died sixteen days postoperatively with meningitis One with a grade II carcinoma died three months postoperatively of miliary tuberculosis Four more died in the first year, 3 of carcinoma, grades II, III, and IV One patient died clinically of sarcoma, but an autopsy failed to demonstrate tumor

Four patients died in the second year, all of carcinoma (3 of grade III, and 1 of grade II) One died in the third year with carcinoma, grade III

Two died in the fifth year, one with a grade II tumor and one without tumor, presumably of coronary disease His tumor was of grade II

One man with a grade IV tumor died in the sixth year of another cause (strangulated hernia)

Of the 15 living patients, 12 are without evidence of tumor, and 3 are alive, probably with tumor Eight of the 12 living, or 53 per cent, have had other treatments for proved recurrences (Table 1)

One patient, living without disease six and onehalf years after operation, had a grade I tumor

TABLE 1 —RECURRENCES OF TUMORS

	Number of Patients	Grades
At 7 months	1	II
At 7 months	1	Papilloma
At 11 months	1	II
At 12 months	ļ	IÏ
At 24 months	1	Ī
At 49 months	1	Ĩ
At 56 months	1	11

In his case radon seeds were implanted in the line One patient, living without tumor of closure eight years and three months after surgery, had a papilloma of the ureter that had extended into the bladder Only five patients who had but the one therapeutic measure, namely, segmental resection. were hving from twelve to forty months later without tumor

Of the 17 patients operated on sufficiently long ago so that they could survive five years, 6, or 35 per cent, did so Five of these are now living, and 1 is dead Of the 5 patients living, the tumors were 1 papilloma, 1 grade I carcinoma, and 3 grade II carcinomas The 1 dead patient had a grade IV carcinoma but did not die of it Of the 6 cases that survived five years, 2 had only one therapeutic measure One was a papilloma, and 1 was the grade IV carcinoma who died of another

Of the 24 cases who could have survived three years, 14 did so (58 per cent) Eleven of these are living, and 3 are dead Of these 14 (5 only had one procedure), 3 were papillomas, 2 were grade I, 8 were grade II, and 1 was a grade IV carcinoma

Summary

Of the 15 dead, only 3, or 20 per cent, died without carcinoma Nine, or 60 per cent, were . known to have died with carcinoma, and 3 died of postoperative complications, possibly with carcinoma

Of the 15 living, 8, or 53 per cent, had proved recurrences which appeared on an average of twenty-seven months after operation, or between seven and fifty-six months after the previous surgery Of the entire group of 30 patients, 17, or 57 percent, were known to have had recurrent tumors

A single segmental resection resulted in 1 fivevear "cure" of a grade IV carcinoma, 1 seven-year "cure" of a papilloma, and 3 three-year "cures" of grade II carcinoma

Conclusion

Apparently, segmental resection can completely remove localized malignant bladder tumors A more careful application of the procedure to a more highly selected group of cases probably will produce a higher proportion of favorable results

URETEROCUTANEOUS ANASTOMOSES

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WHLN radical surgical treatment of carci plated, the selection of a method of permanent unnary diversion was of paramount importance Nephrostomies and pyclostomies are adequate for temporary diversion of urine However, they are unsatisfactory as forms of permanent diversion because of the discomfort and inconvenience of wounds in such a location in addition to the difficulty of maintaining catheters. If the ure ters are intact, their implantation, either into the skin of the abdomen or into the sigmoid colon usually gives more satisfactory results though these latter two types of permanent un nary diversion preserve renal function theoretically, infection and obstruction are likely to obfuscate ideal end results A urotorocutaneous anastomosis drains continually and is dependent on numerous mechanical devices for the collection of urine. Its use in cases with tuberculosis and partially damaged ureters mereases the appli cability of the procedure Ureterointestinal anastomosis in patients with competent anal sphineters requires no apparatus, the patient is free of offensive odors, and, to outward appearances his unnary function is normal

In a review of the literature concerning ureterointestinal anastomosis five to ten years ago, the postoperative morbidity and mortality rates appeared prohibitive, even in the hands of the more experienced operator. The technics appeared difficult and we were practically without experi ence in all phases of the procedure By contrast, the literature of ureterocutaneous anastomosis appeared to offer a method of permanent urmary diversion by a relatively simple technic with low postoperative morbidity and mortality The variety of devices a patient could wear postoperatively seemed to assure the comfort and health of the patient. As cystectomy was the objective and as cystectomy would probably carry a considerable mortality and morbidity of its own, we chose the ureterocutaneous anastomoas considering it the more simple procedure to achieve permanent urmary diversion with less

At present, most of our patients have ureterointestinal anastomoses done preliminary to cystectomy Although long term results are not

available, we have reviewed the cases operated on prior to one year ago to determine whether this transition has been justified by our experience and to study the possibilities for improvement in the results of our ureterocutaneous anastomosis

Review of Cases

There were 50 patients on whom ureterocutaneous anastomosis was performed technic of transplantation varied considerably, but it had in common the placing of the ureters in the iliac region with catheters in the ureters up to the kidney pelvis. In reviewing the cases, the status of each patient prooperatively has had to be determined in order to clarify whether the procedure was done with the hope of palliation or The author has arbitrarily classified the patient's condition as "poor" in the presence of metastases, uremia or other inoperable con ditions. In a second group of patients, the chances were good' only if there were no demon strable metastases at the time of operation and if there was a relatively normal upper urinary tract with a reasonable chance that the patient could withstand a major operation extended to him in hope of a cure or in hope of palliation as in tuberculosis Therefore the classification, "good,' is a purely relative term, since no definite restrictions were considered i.e., the age of the patient or his condition, particularly his ability to withstand an elective procedure. For the purpose of analysis, the patients have been classified according to their diseases, namely, carcinoms of the bladder, tuberculosis, and a group of other diseases.

Carcinoma of the Bladder -There were 32 pa tients with carcinoma of the bladder on whom urcterocutaneous anastomosis was performed In the author's opinion, only 12 of these were in "good" condition The remainder were mainly patients with advanced cancer Of the 12 patients in "good" condition, 7 eventually came to cystectomy In addition to these, 4 patients who were in relatively poor condition on admission came to cystectomy, and 3 of them improved markedly following diversion of the upper unnary tract 1 patient required a cystectomy to control severe bladder hemorrhage. Thus a total of 12 patients were subjected to this procedure Of the 32 patients who had ureterocutaneous anastomosis for carcinoma of the blad der, 4 died before leaving the hospital, giving an

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operative mortality rate of 12 per cent -700H ever, 2 of these patients were in extremis at the time of operation, and 2 died two months after the operation for advanced carcinoma postoperative morbidity which may be definitely attributed to failure of the ureterocutaneous anastomosis to function properly is sometimes confused with the pre-existing renal infection and Two patients developed relatively severe pyelonephritis in the immediate postoperative stage, and 2 other patients developed deep abscesses, requiring incision and drainage, at the site of anastomosis of the ureter and skin were also 3 patients who had a slough of the distal ureter, one of whom required re-implantation of the proximal ureter which had retreated into the retroperationeal space. Hence, there were 7 patients, or over 20 per cent, who had relatively severe complications, during their stay in the hospital, due to the operation per se

Three patients were readmitted because of improper functioning of the ureterocutaneous anastomosis, the difficulty being due to stricture of the stoma or abscesses around the site of transplant. Upper urmary tract studies were not done on the majority of patients, because they would not return to the hospital. However, of the 11 cases we studied one year postoperatively, all had varying degrees of hydronephrosis bilaterally with infected urine. There were 2 cases of stones unilaterally and 4 cases bilaterally, as shown by x-ray. One of the latter cases had a unilateral stone prior to transplantation of the ureters. The incidence of calculi would probably have been higher, had more x-rays been taken.

Most of these patients were in fairly good condition, despite upper urmary tract damage, if their catheters were kept working and if the carcinoma was not too advanced. On relatively slight activity, some of them would get wet, and frequently the catheters would slip out, although a few of the patients managed relatively well.

Although there are only 10 patients alive today, there are 3 survivals for more than five years (9 per cent) and 8 survivals for more than two years (24 per cent) Seventeen patients died of carcinoma of the bladder and 3 of unrelated causes There were 2 deaths from advanced carcinoma of the bladder in which the contributing factors, if not the direct causes, were abscesses of the site of transplantation in 1 case and abscesses of the kidney in the other

Tuberculosis of the Bladder — There were 11 patients with tuberculosis of the bladder on whom ureterocutaneous transplants were performed Five of these were relatively advanced cases of urinary tract tuberculosis. The remaining 6 cases were classified as being in fairly "good" condition, although 5 had already had a nephrec-

tomy In all cases, the procedure was done to alleviate painful and frequent voiding, and this purpose was satisfactorily accomplished. Of these 11 patients, 3 died before leaving the hospital, giving an operative mortality rate of 27 per cent. These 3 patients, however, had advanced pulmonary tuberculosis, and 2 of them died two months postoperatively according to what might be considered the normal expectancy of their pulmonary disease. The ureterocutaneous anastomosis was performed for relief of bladder pain during the terminal stage.

The most common postoperative morbidity which may be definitely attributed to failure of the anastomosis to function properly was caused by deep abscesses in the wound at the site of transplant, but this caused no fatalities were 3 patients (27 per cent) who had such abscesses due to the operation per se There was only 1 patient readmitted because of improper functioning of the anastomosis, she wore no catheter in her ureter, and she developed a stricture of the stoma that required dilating tally, that patient is the only one able to manage a skin cup without an indwelling catheter and also the only one with sparkling clear urine had a normal pregnancy, leads an active life, and appears well, nine years postoperatively other patients we studied had varying degrees of hydronephrosis with infected urine, but no patients among those x-rayed were found to have

Most of these patients were in fairly good condition despite moderate upper urinary tract damage. As a group, they managed their catheters relatively well, although a few would get wet on slight activity. There are only 5 patients of this group alive today. There were 3 survivals for more than five years (27 per cent) and 6 survivals for more than two years (54 per cent). All deaths among these patients were due to generalized and pulmonary tuberculosis, except for a cerebral hemorrhage in one instance.

Other diseases —There were 7 patients on whom ureterocutaneous transplants were performed for reasons other than urmary cancer or tuberculosis. In the author's opinion, only three of these were in relatively "good" condition. The remainder were mainly patients with advanced cancer located outside the urmary tract, causing urmary obstruction with impending uremia, nevertheless. Of these 7 patients, 1 died before leaving the hospital, giving an operative mortality rate of 14 per cent.

In the immediate postoperative period, there was no remarkable morbidity attributed to failure of the ureterocutaneous anastomosis to function properly However, 1 patient was admitted several times for stricture of the stoma with deep

abscesses As a group, the remainder managed their catheters fairly well despite moderate upper urinary tract changes. Three of the operative survivals in this group are known to be dead Of those living today, there are 3 survivals for over two years (42 per cent), but there are no sur vivals for over five years.

Combined Results

There were 50 patients on whom ureterocutaneous anastomoses were performed. The majority (32) were for careinoma of the bladder, the remainder were for tuberculosis (11) and for miscellaneous causes (7). Eight of the 50 patients died before leaving the hospital, giving an operative mortality rate of 10 per cent

Considering that the operative mortality occurred only among those in extremely poor condition, the operative risk of the average candidate for this procedure is not great. Favoring the continuing of the operation is the fact that an occasional poor-risk patient is relieved of uremia and lives a longer time. This operation was performed most often as a palliative procedure rather than for the purpose of curing cancer. The high mortality during the first two years postoperatively in patients with carcinoma paralleled the life expectancy of the carcinoma.

The morbidity due to failure of the uretorocutaneous anastomous to function properly is relatively high, being 20 per cent for the immediate postoperative course Upper urmary tract changes secondary to the catheter drainage are progressive as all patients have varying degrees of hydronephrosis and infected urine fortunate patients tolerated their catheters very This was conspicuous in the tuberculosis patients where their longevity as well as a review of their individual histories, testifies to the efficacy of the ureterocutaneous anastomous for symptomatic relief It is thought by some that the acidity of the urine from kidneys with tuberculosis served as a mild antiseptic besides inhibiting stone formation, which accounts for this differ However, there were 3 patients from the 32 in the carcinoma of the bladder group and 1 patient from the 7 in the third group who fared almost as well. On further scrutiny these more fortunate nationts were all found to be somewhat above average financially and intellectually and had had unusually meticulous medical care. The importance of these 3 factors cannot be overesti mated, since the lack of any one of them invari ably gave poor end results in patients with ureterocutaneous anastomosis.

Unfortunately most patients will not remain without catheters, as they become wet too easily consequently they insist upon ureteral catheters at the expense of progressive upper urinary tract

In this series of 50 patients, the ma jority were not able to stay dry consistently despite the wearing of catheters and numerous in genious devices, however, the infected urine, hydronephrosis, and calculus formation were compatible with life and they were able to carry on for the life expectancy of persons with carci noma of the bladder They disliked the wetness and smell of their ureterocutaneous anastomosis, and friends and relatives disliked them for the same reasons. Those depending upon manual labor for a livelihood were unable to continue due to wetness on activity, while others were turned down on the basis of "failing the physical exami nation,' probably as a result of prejudice of emplayers who felt that they would prove offensive in public contacts Hence they were frequently relegated to financial dependence When metastases and further advancement of the cancer came upon these patients they were invariably turned away from private nursing homes and religious institutions where patients with other forms of terminal cancer were acceptable on the basis of their ureterocutaneous anastomosis requiring hospital care. Thus having led lives of enforced chronic invalidism, penniless, and socially banished, they staved home tinkering with the vicissitudes of the catheters in their ureters while their lives swayed in the balance of renal failure

Despite the dismal lives of the majority of these patients one must remember that some, such as the tuberculous group fare quite well, and that it is the only reasonable method of transplantation in patients with colostomies or incompetent anal sphincters. Because of the simple technic of the operation and the low operative mortality rate, even among extremely poor risks, the procedure does not have to be withheld from anyone it might help. However, the intellectual and financial status of the patient and possibility of the patient's having meticulous care taken of his ureterocutaneous anastomosis must be kept in mind if a satisfactory result is to be achieved.

Comment

Reviewing the follow up studies on patients who had ureterocutaneous anastomous, one is likely to form impressions which go beyond the factual data heretofore presented. The sad plight of a few patients and the successes of others may distort the value of certain facts and warp our perspective. However something may be gleaned from studying these patients, both by a careful perusal of records and by a personal ac quaintance with many of them established during a period of years of caring for them. From such a viewpoint, the author has formed impressions which may be related at this point.

mizes the possibility of catheters slipping out or being adjusted at the wrong level subsequent to boiling and replacement. Regular periods of changing the catheters should be adhered to rigidly, and an adequate apparatus for the collection of urine should be established and adjusted by the urologist. By following the above technic and regime, the optimal type of ureterocutaneous anastomosis may be established and maintained. A patient deserving of a ureterocutaneous anastomosis deserves a good one, and every effort should be made to insure this

Conclusions

Our follow-up experience in 50 cases of ureterocutaneous anastomosis shows us that the majority of patients fared badly, both socially and economically. They also had progressive upper urinary tract changes added to the wees of their unhappy catheter existences. The minority, those who managed well, were above average intellectually and financially and had meticulous care taken of their catheters. A cutaneous anastomosis gives better results if the patient can stay dry using skin cups without catheters.

Despite the shortcomings of ureterocutaneous anastomosis in our experience, it must be recognized as having a definite value in treating certain types of patients. We believe that the type of cutaneous anastomosis that we are performing at present will prove more satisfactory. However, if all ureterocutaneous anastomoses proved optimal, they could never rival the more satisfactory follow-up of ureterointestinal anastomoses.

EROINTESTINAL ANASTOMOSES

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known to be simple and to be associated with a low mortality. After some study, the Coffey I intraperitoneal method was chosen, because it was simple, required no special instruments, and, according to reports, was as successful as other methods.

The postoperative mortality of this operation, used on 108 consecutive patients, has been 12 per cent, which is encouraging, although by no means ideal. This group includes patients between the ages of four and eighty-two, 3 were children, 105 were adults (15 in their seventies). Indications for operation are shown in Table 1. Only 3 deaths in this group were due to complications in the peritoneal, gastrointestinal, or genitourinary tracts. The remainder of the fatal

TABLE 1 -- INDICATIONS FOR OPERATION

Condition	Number of
rinoms of the bladder and posterior urathra illomatoris of the bladder	. 94
tiation evatitie	5
rophy of the bladder mary incontinence	_3
Potal	108

inlications were nonspecific for this operative anic, as shown in Table 2 Nine and ninethe per cent had nonfatal complications while the hospital (Table 3) A more rigid selection patients would be likely to reduce both the ortality and morbidity but most of the patients 'nsidered poor risks had no difficulties on, alone, was the indication for operation in 2 cases

TABLE 2,-POSTOPESATIVE FATAL COMPLICATIONS

Complication	Number of Cases
Peritonitis Intestinal obstruction Cardiac failure Cerebral vascular accident Pulnonary infarction Generalized septis Subsequent surgery	1 4 1 2 1
Total	13

FABLE	3 -POSTOPERATIVE	NONFATAL	COMPLICATION
C	omplications	Numbe o	Percent
Wound	infection	3	2 7
Wound	separation	1	0.9
Pulmon	ary embolus	1	0.9
Phlebiti		1	0.9
Edema	(hypoproteinemia) I accident	1	0.9
Cerebra	accident	i	0.9
Corona	y thrombosis	1	0 9
Tempor	ary nephrostomy	2	18
	• • •	_	_
Total		11	9 0

The follow up in this somes varies from four months to five and one-half years. Fifty-eight are known to be dead all in this group have died with or from carcinoma except 1 patient who died of renal failure As shown in Table 4 permanent diversion of the urine, subsequent to ureterointestinal anastomosis was necessary in 4 patients although 2 others had mild uremic symptoms. In one patient an abscess developed around the transplant two weeks after discharge

TABLE 4 -LATE COMPLICATIONS

Complications	Number of Cases	Percent age
Diversion of urinary stream Cutansom uretroelcomy Bilateral nephrostomy Aberes about Tramplant Uranic symptome	3 1 1	3 1 1 0 2 0
Calculus formation (one had calculus removed before operation) Nonfunctioning kidneys Clinical pyclonephritis (all recovered)	3 8	2 1 8 4 8 4
Total	25	27 1

Renal calculi formed twice but 1 case had had a previous nephrolithotomy Attacks of pyelonephritis have occurred in 8 patients, all recovered completely without the necessity of surgical intervention The attacks of pyelonephritis were not severe and were usually represented by a dull ache in the flank, rather than chills, fever, and severe flank pain

In other words, clinical pyclonophritis has not been the major problem as was first anticipated Eight patients have developed nonfunctioning kidneys, as determined by intravenous pyelo-Therefore, one of the main objectives of the operation should be to avoid obstruction (as revealed by intravenous pyelography) A classification of the postoperative pyelograms is presented in Table 5 where the size of the poor group is impressive On the other hand, it must be pointed out that the classification is strict and that many patients with pyelograms in the poor group have lived for years without difficulties

TABLE 5 —CLASSIFICATION OF PYELOGRAMS				
Group	Criteria for Classification	Pe		
Excellent	Indistinguishable from preoperative films		8	
Good	Normal pyelograms or those abowing a return of function or decrease in hydronsphrosis when compared to the preoperative films		1	
Intermediate	Excellent function in ten minutes with Grade I hydronephrosis	19	1	
Poor*	All others	43		

* The noor group appears large on account of the strict classification used, but it should be remembered that patients with pyelograms in this group have lived for years.

With occasional exceptions, the renal status and personal comfort of these patients have been excellent, and poor late results nearly always have been due to far advanced caronoma. In general, the patients retain urine for two to three hours during the day and five to six hours during the night. The anal sphincter was tested in each case before the operation, and no instance of rectal incontinence was encountered after the ureterointestinal anastomosis However should be pointed out that the anal sphincter may be damaged at the later total abdominopermeal cystectomy, with resulting incontinence, a situation which occurred once in this series

Conclusions

Two hundred and sixteen consecutive ureterointestinal anastomoses by the Coffey I transperitoneal method have been reported with an operative mortality of 12 per cent. When it is considered that this is less than one fourth the postoperative mortality reported in 1937 this mortality rate is a satisfying achievement, although not ideal Seventy-seven and one

SYMPOSIUM

tenth per cent of the cases had a smooth, uneventful postoperative course, 271 per cent developed late complications. There is no doubt that a 12 per cent mortality is considerably higher than that obtained on a similar group of cases by ureterocutaneous transplantation. However, it is felt that the merits to the patients following ureterointestinal anastomosis by far overshadow the increased risks Consequently, the latter procedure is done wherever possible

The patients with bowel transplants are able to lead normal lives socially and economically They are not earmarked as being "different human beings" by the wearing of "complicated apparatus" that necessitates expert care, frequent changing, or daily irrigation

TOTAL CYSTECTOMY

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TOTAL cystectomy is being employed with Lincreasing frequency as a method of treatment of bladder tumor This is due to several The first is the realization that such factors apparently conservative measures as radiation therapy, simple fulguration, transurethral resection, and segmental bladder resection leave much to be desired in regard to both cure and palliation Second, the improved surgical technics for diversion of the urinary stream, particularly ureterointestinal anastomosis, result not only in decreased operative mortality but in decreased morbidity and improved pyelographic The third factor is the diminished operative mortality and morbidity from total cystectomy

The present series comprises all cystectomies done for genitourinary tumors on the Urological Services of the New York Hospital (Cornell Service) and Memorial Hospital during the years 1940 through 1946, inclusive The follow-up figures are based on data through the year 1946

The following analysis is presented primarily to demonstrate the feasibility of total cystectomy as an operative procedure. The follow-up data are presented only to complete the survey at this time and with the full realization that a further analysis of this same series five years hence may modify considerably some of the present tentative conclusions.

One hundred and five cystectomies (Table 1) were performed during this seven-year period Of this number 98 were done for bladder tumors, 4 for urethral cancer, 1 for carcinoma of the prostate, 1 for carcinoma of the penis and multiple bladder papillomata, and 1 for a vaginal cancer which had invaded the bladder

TABLE 1 —Indications in 105 Cystectomies for Genito-Urinary Tumors

Bladder tumors* (81 men 17 women) Cancer of bladder Papulloma of bladder	98 89
Urethral cancer (3 women 1 man) Carcinoma of the prostate	4
Carcinoma of base of penis and history of multiple bladder papillomata Vaginal cancer invading the bladder	1 1

^{*3} men patients who had bladder tumors also had carcinoma of the prostate (3 6 per cent of all men)

The average age of the patients in this series was fifty-nine and six-tenths years, the oldest was seventy-eight, the youngest, thirty-eight In 81 instances the ureters were transplanted to the bowel, and in 24 instances they were transplanted to the skin

The technic of operation (Table 2) was varied to meet individual needs. With the 84 men, the perineoabdominal approach was employed 68 times and the suprapubic route, alone, 16 times. With the 21 women patients the suprapubic approach was employed 11 times, the perineoabdominal approach 3 times, and in 7 cases the

TABLE 2 —OPERATIVE APPROACH IN 105 GENITOURINARY TUMORS

2 OHOIIS				
Operative Approach	Numbe Men	er of Cases— Women		
Penneoabdominal Suprapubic Vaginal	68 16	$\begin{smallmatrix} 3\\11\\7\end{smallmatrix}$		
Totals	84	21		

bladder was removed entirely by the vaginal route

There were 6 postoperative deaths (Table 3), a mortality of 5 7 per cent

There were 14 postoperative complications (Table 4), an incidence of 13 3 per cent. Of these 7, or 6 7 per cent, were severe, and the remaining 7 were mild. Conversely, 81 per cent had a smooth postoperative course.

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TABLE 3 -- POSTOPERATIVE DEATES

Man, aged 60	Died on twenty fifth postoperative day De- vrioped collapse of cervical vertebra due to previously unrecognized metastasis and died of respiratory paralysis.
Man aged 63	Died three hours postoperatively Class 4 cardiac. Cystectomy was performed virtually as emergency to control hemorrhage when more conservative measures falled
Man aged 62	Died two hours postoperatively Extensive bronchiectasis. Death resulted from occlu- sion of left main bronchus by mucous plus with complete collapse of left lung and medisatinal shifts.
Man, aged 78	Died on twenty-econd postoperative day Developed cardian failure followed by bronehopneumonia and terminal uremia (econdary to cardiae failure)
Man, aged 7"	Died on thirty third postoperative day Daveloped wound infection, followed by eviscaration followed by fecal fistula
Man, aged 68	Died on sixth postoperative day of earabral hemorrhage

it could be inferred that patients who survive more than two years after cystectomy are usually free of tumor. There are 3 five-year survivals without evidence of disease in the group of 4 patients done five or more years ago. The successful results in the earliest patients treated by cystectomy can be attributed partly to chance and partly to the extreme care used in selecting candidates for the operation.

One might logically expect better results in cases in which systectomy was done immediately than in those cases in which a more conservative initial treatment proved unsatisfactory and ultimately required cystectomy. This could not be demonstrated in the present series however (Table 6).

TABLE 4 -- POATOPERATIVE COMPLICATIONS

	7 Severe Complications		7 Mild Complications
Man, aged 60	Trauma of nerves of left leg due to spinal anesthesia	Man aged 57	Postoperative fleus. Probable right lower lobe ateleptaris
Man aged 65	Vasomotor collapse due to myocardial weakness during perineal portion of oystectomy requiring completion of abdominal portion at later date	Man, aged 71 Man, aged 69 Man, aged 60 Man aged 69	Mild cardiac decompensation Mild carebrovascular accident
Man, aged 63	Postoperative hamorrhage from perineal wound requiring packing Probable left common like vein thrombosis	Man aged 53 Man aged 51	Mild left pyclonephritis Mild thrombophlebitis, both legs
Woman, aged 68	Coronary thrombosis on first postopera		
Man, aged 61	Fecal fistule due to operative trauma (previous excessive radiation)		
Woman, aged 62 Man, aged 63	Feed fistula due to residual cancer Postoperative partial anal sphinoter in- continence (due to operative trauma)		

TABLE 5 -FOLLOW UP ON 105 CTSTECTOMIES FOR GENTTOURINARY TUMORS

3-4 years 2-3 years 1- years	Alive—No Evidence of Disease 1 (74 months) 2 (average, 66 months) 1 (48 months) 7 (average 25 months)	0 0 0 5 (average 15 months)	I (average 18 months)	Dead with Tumor or Renal Failure 0 1 (21 months) 7 (average 19 months) 8 (average, 11 months) 7 (average, 9 months) 14 (average, 3 months)	Total Number 1 3 8 3 18 21 51	Per cent Allve— No Evi dence of Disease 100 66 7 12 5 0 38 9 38 1 50 9	
	45	;; • • • • • • • • • • • • • • • • • •	. .				
A VIALE	10	10	•	EC .	105	42 9	

From the follow-up data (Table 5) it is seen that almost half of the cystectomics were done during the year 1946, and almost three fourths in the two-year period of 1945 and 1946 Forty-five or 42 9 per cent, of the 105 were alive without evidence of disease at the end of 1946 Twenty six, or more than half of these 45 patients, were operated on during the last year, and the follow up period is obviously too short to be significant. It is interesting however, to note that of the patients alive with disease none was operated upon more than two years ago This observation gains lurther significance when it is noted that patients who died with disease usually did so within two years of cystectomy Conversely

TABLE 6—RELATIONSHIP OF PREVIOUS TREATMENT TO NUMBER OF PATIENTS ALIVE WITHOUT EVIDENCE OF DISEASE (BLADDER TUMORS, ONLY)

	Alive—No Evidence of Disease	Total Number	Per cent Alive—No Evidence of Disease
Patients who had had previous treatment Patients whose first	19	45	47 2
treatment was cys- tectomy	22	53	48 4

A comparison (Table 7) was made between cases in which there was no preoperative or operative evidence of local extension or metastasis and cases in which there was a serious question of operability as evidenced by possible metastasis the presence of a palpable tumor on

TABLE 7—Relationship of Operability* to Number of Patients Alive without Evidence of Disease in (Bladder Tumors Only)

	Operable (64 Cases)	Palpable Tumor	Patients Conside Questionably O Induration of Bladder Base	red perable (34 Cases) Suspicious Lymph Nodes	Pos Lyi No
Total number Alive—no evidence of disease Per cent alive—no evidence of disease	64 30 46 9	6 8	24 9	3 0 5 3	1

^{*} Operability as estimated by preoperative bimanual examination and by abdominal exploration at time of ureter plantation

examination, induration of the bladder base on rectal examination, or the finding of enlarged iliac lymph nodes at the time of exploration In the present series the outlook seems more favorable when these signs are not present

The chance of cure seems to be greater with tumors of less than 2 cm diameter than with larger tumors (Table 8)

TABLE 8—RELATIONSHIP OF SIZE OF TUMOR TO NUMBER OF PATIENTS ALIVE WITHOUT EVIDENCE OF DISEASE IN 98 CASES OF BLADDER TUMORS

		Alive—No Evidence of Disease	Total Number	Per cent Alive—No Evidence of Disease
	Patients with tumors 2 om or larger in diam- eter Patients with tumors	23	69	33 3
•	less than 2 cm in diameter Patients in whom size of	12	18	66 7
	tumor was not speci- fied	7	11	63 6

Multiplicity of tumors has no apparent influence on the number of patients alive without evidence of disease (Table 9)

Conclusions

- 1 Total cystectomy is a feasible metreatment of bladder tumors. The tion has been performed in a series patients with genitourinary tumors w operative mortality of 5.7 per cent and a cotion rate of 13.3 per cent.
- 2 The short follow-up in the majo cases presented has obviously influenced analyses relating to the number of patien without evidence of disease According dogmatic statements in this regard are just On the basis of this preliminary survey, he one can make the following tentative conclusions.

Patients who survive two years vevidence of tumor seem to have a good pro: "cure"

Patients who have cystectomy as the treatment seem to have no better chance than those who have preliminary contive treatment with ultimate cystectomy

TABLE 9 —Relationship of Multiplicity of Tunors to Number of Patients Alive without Evidence of in 98 Cases of Bladder Tunors

	Papilloma of		Carcinoma of		Bladder Tumor		
	Bladder		Bladder		(Papilloma and Caron		
Patients with single tumors Patients with multiple tumors Patients with number unspecified	Alive—No Evidence of Disease 2 6 0	Total	Alive—No Evidence of Disease 24 10 0	Total Number 58 27 4	Alive—No Evidence of Disease 26 16 0	Total Number 61 33 4	Ali Ev of

As is expected, the number of patients alive without evidence of disease decrease progressively as the histologic grade of the cancer increases. The system of grading employed does not classify papilloma, even with atypical cells, as cancer (Table 10)

TABLE 10 —RELATIONSHIP OF GRADE OF BLADDER TUMOR TO NUMBER OF PATIENTS ALIVE WITHOUT EVIDENCE OF DISEASE IN 98 CASES

	Total	Alive-No Evidence of	Per cent Alive—No No Evidence	
Grade	Number	Disease	Disease	
Papilloma Carcinoma	9	8	88 9	
Grade I	13	9	69 2	
Grade II	13 34	5	38 5	
Grade III-IV Unclassified	34 29	10 10	29 1 34 5	

Estimates of operability obtained by bi examination and by exploration at the of urinary diversion are of some value inosis

Tumors, 2 cm or more in diameter, sociated with a definitely poorer prognos those less than 2 cm in diameter

Multiplicity of tumors per se seems to l influence on prognosis

The higher the grade of the bladder the poorer the prognosis

SUMMARY AND CONCLUSIONS

VICTOR F MARSHALL M D, New York City

(From the Department of Urology Cornell University Medical College, New 1 ork and Memorial Hospitals)

TROM this symposium on the treatment of the Lusual bladder tumors, the trend away from radiation toward radical surgery should be evident Although an occasional, successful fiveyear result was obtained by relying on radiation, the results for the whole group were not only bad, but also little or no palliation was obtained. No common denominator exclusive to the successful cases could be found to provide criteria for the future selection of cases which might obtain a good response to radiation Naturally low grade tumors seemed to be more successfully treated than high grade ones but this is true regardless of method of therapy A comparison of the radiation treated group with the general population and with reports on untreated bladder cancer patients made our failure stand out more un pleasantly

The radiation group, being fairly large consecutive and with a reasonable follow up of at least five years, is the basis for a fairly definitive study, but the remaining presentations are not They are really current inventories of relatively recent cases. However, at this stage they are the best guides available to us after leaving the base lines of the general population untreated cancer,

and the radiation group

Dr McLellan has indicated that simple physi cal destruction by fulguration does produce excellent results at times However, the vast majority of the successful cases had not only small tumors but also a low grade of malignancy In fact, cases with so-called benign papilloma constituted the bulk of the good results although even here multiple recurrences and poor outcomes were not unknown Furthermore, McLellan s cases were selected for fulguration from a fairly large number of bladder tumor cases patient s symptoms were seldom increased and were often decreased temporarily even though tumor recurred The temporary control of hemorrhage alone will save the method from oblivion When the bulk of the tumor is cut off a really adequate biopsy is usually obtained which is valuable for prognosis and later studies One real danger of this method stems from its good points with symptoms decreased with the patient pleased, with the inability to be certain that residual tumor is present, and with the knowledge that some cures are thus produced, the urologist may miss the opportunity of saving a failure by the use of some other method

Dr Drew's series of patients having segmental resection of the bladder is even more selected than Dr McLellan's On the other hand it seems evident that the group was not selected highly enough, since the end results have not been good In general, the lesions were both larger and of higher grade malignancy than those chosen for fulguration alone Reimplantation of the ureter as a surgical maneuver was highly successful, but when done to remove the actual site of the tumor father than merely to obtain margin, it usually resulted in recurrence unless the lesions were on histologically benign pedicles. If the bladder shows a tendency to multiple originations of tumors, segmental resection offers a very poor prophylaxis

Surgically, the next consideration is total removal of the bladder, but first of all the results from the two most feasible methods of permanent urnary dryerson must be considered

Dr Humphreys has shown that ureterocutaneous annatomosis is not a risky operation of itself, but the long term morbidity has been great. The wearing of cups without catheters would most likely have improved our results but even so few of us would care to put up with the many inconveniences of skin transplants if there were any other way out. On the other hand, transplantation of the ureters to the skin does have a valuable, and at times necessary, place in the treatment of difficult and complicated cases

The report of Dr Schnittman on ureterointestinal anastomosis reveals a somewhat high mortality of 12 per cent, but his analysis of the deaths shows that many of the patients were poor risks. At the same time, many poor risk patients got along well Should we select our candidates more rigidly and thereby deny ureterointestinal transplantation to a good number of poor risk patients who would get along well? Personally, I would rather attempt to apply the procedure to a still larger field by continued study and perfection, realising that the percentage of cures at five years is so low that even the occasional saving of a poor risk patient at the price of a high percentage of immediate mortality would be worthwhile One must remember, too that the usual un treated patient is by no means asymptomatic Dr Schnittman however, has rightfully stressed the usual comfort even though perhaps not per-

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manent, and social acceptability of the patients with ureterointestinal anastomosis also be pointed out that the later poor results in patients with intestinal anastomosis have been due more often to cancer than to renal disease The procedure cannot reasonably be done on all bladder cancer patients The technic is not to be undertaken lightly, as attention to many seemingly unimportant details is usually the difference between success and failure

The consecutive series of patients having total cystectomy reviewed by Drs Whitmore and Beall is not as encouraging as would be desired Many have died of cancer so that it can already be seen that a really high cure rate will not be obtained We would be pleased, although not delighted, with a 12 per cent successful five-year result rate Judging from statistics on other internal cancers and from our own experience, it is extremely improbable that a 50 per cent cure rate can result from our present methods, indeed, a 331/3 per cent rate would be astounding. The operative mortality was low, and the palliation In fact, some cystectomies were performed solely for palliation and a few just to pre-We have favored the vent exanguination perineal abdominal approach as providing for the most definite removal of the important marginal tissues, consisting of the prostate and vesicles , dependent drainage via the perineum seems

In special cases vaginal or vaginal prapubic cystectomy has been worth while Unless the tumor is well removed from the bladder base and outlet, we prefer not to limit ourselves to the suprapubic approach

From all this data and, necessarily, from other facts as well, I will attempt to give very briefly our present inclinations for therapy of bladder tu-

Of course, there are many considerations with the individual patient, but in the items to follow let us consider the patient as being in excellent condition other than for the tumor itself

Local excision and fulguration for simple papillomas as their first treatment

Segmental bladder resection, with or without ureteral reimplantation, for a highly selected group with early, preferably low grade, cancers so located that excessive margins can be obtained, and where there is no tendency to multiple origination in the bladder

Ureterointestinal anastomosis by the Coffey I method followed by total cystectomy for all Grade II, III, and IV cancers, which are locally mechanically removable

Most grade I cancers are treated by cystectomy, but a select few are treated other-Nearly all recurrent cancers also fall into this group, as do a selected number of papillomatosis cases, especially those with rapid and bulky recurrences

Skin transplantation of the ureters is reserved for the most difficult and desperate cases

Radiation used against known 6 18 metastases and occasionally against the locally inoperable bladder cancer, especially after skin transplantations

Perhaps some improvement with the Grade IV cancers, and those rare, extremely rapidly growing cancers, might result by adding heavy radiation to surgical excision We use it, there-

Finally, let me emphasize that the term "cancer," as it is used in these talks, does not include papilloma as grade I

THE GREAT HERBAL (PÊN TS'AO KANG MU)

The Army Medical Library has acquired a 19th century edition of Li Shih-chên's famous Chinese "Great Herbal" (Pên Ts'ao Kang Mu), in 52 volumes The original of this work was published in 1596, shortly after the death of its compiler, who is said to have labored on it for almost thirty years The introduction to the work states that in his will Li Shih-chên commissioned his son to submit it to the emperor Shén Tsung, who thereupon authorized its publication

Although it is commonly translated as "The Herbal," the Pên Ts'ao Kang Mu is actually a complete materia medica. Three of its supplementary volumes consist entirely of very fine woodcuts illustrating the animals, plants, and minerals which form the basic substances of all the drugs described in the

work itself The other additional volumes contain a preface, an introduction, and an index of diseases

The idea of the Pen Ts'ao is of great antiquity and the first such "Herbal" is traditionally ascribed to Shên Nung, the Divine Husbandman and God of Medicine, a legendary emperor who is said to have reigned from 2737 to 2697 B C By the time when Li Shih-chên began his task, about five hundred dif-ferent Pên Ts'ao had been compiled His work represents a critical study of 1,578 prescriptions contained in the earlier works on this topic, to which he added 358 new drugs, including those derived from tobacco and opium. Its antiquity does not detract from the present value of the book and Chinese physicians are still in the habit of consulting it -Army Medical Library News, February, 1948

STREPTOMYCIN IN CLINICAL TUBERCULOSIS

Carl Muschenheim, M D , Walsh McDermott, M D , and Paul A Bunn, M D , New York City

(From the Department of Medicine, Cornell University Medical College and the New York Hospital)

THE discovery of streptomycin by Schatz. L Bugne, and Waksman and their demonstration of its powerful in vitro activity against the tubercle bacillus was followed quickly by Feld man and Hinshaw's careful therapeutic expen ments in animals.1 It is remarkable that in the short space of a year these investigators so thoroughly established the therapeutic potentiali ties and limitations of the drug in experimental tuberculosis that the exploration of its clinical possibilities could be undertaken on a secure basis late in 1944 Within the next two years the Mayo Chnic group had already treated 100 patients? Their early results established that streptomycin can profoundly and favorably modify the course of at least some cases of tuber culosis in humans. Such an unequivocal effect had not been previously demonstrated with any other clinically feasible chemotherapeutic agent, and this early promise is currently being tested in a large number of clinics The clinical study at New York Hospital on which this paper is based was begun early in 1940, under the auspices of the National Research Council and is now part of a cooperative project conducted by the American Trudeau Society and the National Institute of Health

Nearly 60 patients with various forms of tuber culosis have been treated in the period since January, 1946 when the study was started. The cases are mainly of three clinical types (1) generalized hematogenous tuberculosis, mostly of the acute miliary variety, (2) tuberculous meningits and (3) pulmonary tuberculosis, with and with out complicating bronchial, laryngeal, or other extrapulmonary tuberculosis. In a few patients acute, generalized, hematogenous dissemination had developed in the course of chronic pulmonary tuberculosis so that there is some overlapping of these categories. In general, however, the cases are either hematogenous, with or without meninguis, or of the pulmonary form

As the problems of optimum desage and duration of treatment have not yet been answered, either for the most immediately threatening acute hematogenous forms or for the chronic pulmonary forms the regimens used in the present series are not necessarily to be recom-

Presented at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo Session on Chest Diseases May 8 1947 mended Inasmuch as the study was first undertaken with a view to an evaluation of toxicity, the cases first selected were mostly of extreme seventy and in advanced stages of progression. Doses which might now be considered maximal were therefore employed A total daily dose of 3 Gm intramusoularly was used in adults This was divided into individual doses of 0.375 to 0.5 Gm given in 6 or 8 injections The duration of treatment was varied nally, a continuous course of one hundred twenty days was given, but this was extended in a few instances and greatly shortened in some of the more recent cases for reasons which will be discussed later In cases with meningitis, intra thecal administration in average daily doses of 005 to 02 Gm. was added to the basic intramuscular therapy Current and proposed modi fications of daily dosage schedules need not be detailed here, but it should be mentioned that they are in the direction of smaller total doses and less frequent injections

The duration of follow-up is yet too brief to permit a discussion of results on anything more than a preliminary and tentative basis. As far as the demonstration that streptomyon actually does have a recognizable effect on tuberculous disease in humans is concerned, however only a brief experience in the treatment of but a very few cases of miliary tuberculous and tuber culous meningitis is necessary to be completely convincing In these heretofore most certainly and most rapidly fatal forms of tuberculosis the effects of treatment are most easily measur able in terms of prolongation of life from the usual few weeks to many months Remissions have been observed regularly even in patients who seemed moribund. The improvement is usually rapid and of an extent which is seen only with the greatest rarity, if ever, in the natural course of the disease. Such remissions in miliary tuberculosis, for instance, have been characterized not alone by subsidence of fever and all other symptoms but by an accompanying regression of advanced miliary lesions in the lungs even to the degree of complete disappear ance of the roentgenographic shadows. In tuberculous meningitis similar complete symptomatic remissions have been produced with the return of all spinal fluid changes to normal, including sterility on culture. For completeness

manent, and social acceptability of the patients with ureterointestinal anastomosis also be pointed out that the later poor results in patients with intestinal anastomosis have been due more often to cancer than to renal disease The procedure cannot reasonably be done on all bladder cancer patients The technic is not to be undertaken lightly, as attention to many seemingly unimportant details is usually the difference between success and failure

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were merely palpable and no longer visibly enlarged, and the chest roentgenograms had meanwhile shown complete clearing of all abnormal shadows cast either by the enlarged mediastinal lymph nodes or the miliary disease in the lungs. Cultures of gastric washines and sputum which had previously been positive were now negative for tubercle bacilli. The spinal fluid became virtually normal after conclusion of the course of intrathecal streptomycin Despite continued intramuscular administration of the drug relapse occurred early in this patient with reappear ance of fever and all other symptoms, recurrence of visible enlargement of superficial lymph nodes some of which broke down and formed cutaneous sinuses and return of rountgenologically demonstrable miliary lesions in the lungs. The course was now rapidly progressive and terminated fatally seven weeks after the clinical onset of the relance and five months after the institution of treatment. The bacilli isolated from this patient originally were sensitive to less than 1 microgram of streptomycin per ec. of medium in vitro During the clinical remission the cultures were sterile so that the exact time of development of bacterial drug resistance is not determined. The cultures isolated early in the relapse period, however were resistant to concentra tions of streptomycin in excess of 1 000 micrograms per ce It seems probable therefore that the development of resistance was the principal factor responsible for the therapeutic failure although the hyperacute character of the disease and its advanced stage of progression before treatment may also have contributed to the poor ultimate result. It is of interest to note that there was no clinical evidence of relapse of the meningitis accommanying the reactivation of the generalized disease and that the meningeal involvement found at autopsy was of minimal extent. The occurrence of meningitis late in the course of generalized miliary tuberculosis which has responded favorably to streptomycin has been observed in other cases but is not necessarily to be anticipated.

A type of relapse and failure opposite to that described above has been encountered. This consists of relapse of the meningitis in the presence of apparently completely healed miliary tuberculous in organs other than the brain and meninges In one such case, examined postmortem, the only residues in the lungs of what had originally appeared roentgenologically as typical disseminated lesions of miliary tuberculosis were irregular fibrous nodules visible only These contained no inflamma microscopically tory or giant cells to indicate their tuberculous origin. The gross and histopathologic evidences of healing in streptomyoin treated miliary tuber culosis were well described by Bagenstoss, Feldman, and Hinshaw 3

Pulmonary Tuberculosis

Evaluation of the effects of streptomycin in pulmonary tuberculosis is a problem of much

greater difficulty than in the more uniformly fatal forms of tuberculous disease previously described Because of the well known spontaneous tendency to healing and the unpredictability of the clinical course, direct comparison of treated and untreated cases lacks arenificance unless a large number of variable factors are taken into consideration. Furthermore, the multiplicity of these factors and the resulting vari ability in the clinical picture make it virtually impossible to conduct a control study by treating consecutive alternate cases. Finally, the inaddiousness of pulmonary tuberculosis often results, even before symptoms are noticed in establishment of much destructive change which is in some respects irreversible. Even with the most ideal chemotherapeutic agent, healing of chrome fibrous-walled cavities would be expected to take place slowly, if at all Dramatic improvements, such as have been seen in the acute hema togenous forms, might, therefore, be anticipated only in the acute exudative forms of the pul-This has indeed been the case monary disease There are a few instances only among the cases of pulmonary tuberculosis treated in the present study which show such unprecedented improvement, unequivocally attributable to the drug, as is the rule among the acute hematogenous cases It is significant that there should be any improvement, and it requires only a moderate familiafity with the natural history of the disease to rec ognize the effect in early progressive exudative cases of the acute pneumonic type. In these and indeed in practically all cases with fever and other toxemic manifestations, whether early or late, there is usually a prompt symptomatic response, appreciable within a few days. Fever subsides or is markedly reduced appetite improves, and there is gain in weight and strength More importantly, there is usually also reduction in cough and expectoration regression of infiltrative roentgen shadows in the lungs, and shrinkage of cavities Only in the early cases, however, is the maintenance of the symptomatic improvement usual and cavity closure or sputum conversion frequently attained In cases with established secondary changes of extensive caseation, long-existing and large-sized cavities, and considerable fibrosis, the objective improvement rarely proceeds to the immediate therapeutic goal of disappearance both of visible cavities and recoverable bacilli in sputum or gastric washings. Moreover, in many instances, the favorable trend is eventually reversed, and progressive tendencies are resumed The time of such resumption of progressive manifestations, as reappearance of fever, exacerbation of other symptoms, enlargement of cavities and occurrence of bronchogenic spread is variable

of remission, then, the streptomycin treatment of these forms of tuberculosis can be compared to the penicilin treatment of subacute bacterial Unfortunately, not as much can endocarditis be said for the frequency of permanent cure or prolonged arrest of the disease Relapse is only too frequent and in some instances has occurred even while treatment was still in progress, presumably because of the development of bacterial resistance to the drug In these cases, the subsequent course has been rapidly progressive with reappearance of all of the usual manifestations of overwhelming tuberculous infection and fatal termination

Acute Miliary Tuberculosis and Tuberculous Meningitis

No detailed numerical account of the results to date in the meningitis and acute generalized hematogenous cases will be presented. Suffice it to say that among the 15 cases in these groups, there are only 2 miliary and 3 meningitis cases now in satisfactory remission with a maximum follow-up period of four months since the end of treatment. The others have all relapsed and died or are doing poorly

A single example is sufficient to illustrate both the unprecedented improvement which can be effected by streptomycin and the difficulties which may be encountered to preclude a successful long term result Case 1—The patient was a 21-year-old man with an hyperacute, generalized miliary tuber-culosis associated with cervical and mediastinal lymphadenitis. The enlargment of the lymph nodes was extreme and had developed rapidly

Before treatment with streptomycin, the patient had daily temperature elevation ranging to 103 or 104 F (Fig 1) This high fever had been present for at least two weeks prior to hospital admission From the earliest symptoms of malaise and slight fever, the entire illness had developed within a When streptomycin treatment was started, month there followed a rapid decline of fever and corresponding improvement of the other prominent symptoms of drowsiness, weakness, drenching sweats, and, The enlarged superficial lymph extreme anorexia nodes in the cervical region, some of which had attained massive size, promptly began to shrink The drowsiness, amounting almost to stupor, gave place to alertness The appetite became normal, and a rapid weight gain ensued Despite this general improvement, however, the temperature again rose after its initial decline and early in the second month of treatment had resumed a high level patient at this time complained of headache, and although there were no objective signs of meningeal irritation, a lumbar puncture was made fluid cell count was 175, and although no acid fast bacıllı were demonstrable, ıntrathecal admınistration was begun and continued for twenty-eight days The temperature again declined to the normal range, and during the ensuing five weeks, the disease was apparently in complete remission. There were no toxemic symptoms, the superficial lymph nodes

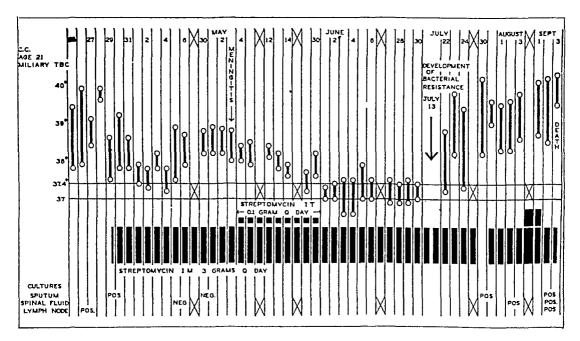


Fig 1 Course of acute miliary tuberculosis treated with streptomycin Vertical lines indicate highest and lowest rectal temperature recorded each day

Conclusion

The material is necessarily too small and too diverse for statistical analysis and the follow up period too short for appraisal of end results. The trend, however, appears to justify the feeling that streptomycin may on further evaluation prove to be a permanent adjunct to more established methods of treatment of pulmonary tuberculosis Everything in the present experi ence supports the opinion of Hinshaw and his coworkers that streptomycin is suppressive rather than curative and cannot be expected to eradicate well-established tuberculous infection in humans. In this respect its action resembles that of other antibacterial agents in other in fections, although the similarity may be clinically obscured in the more acute diseases.

The observations on toxicity attributable to streptomycin in the present study have been reported elsewhere '* These confirm the results of others which indicate that the disturbance of equilibrium encountered regularly in greater or less degree, is the most important untoward reaction. With overdosage or in the presence of renal insufficiency, there is also risk of deafness, as there is with intratheeal administration.

Only two unequivocal indications for streptomyon treatment of tuberculous can be said to exist at present. These are tuborculous moningitis and acute generalized miliary tuborculosis. In pulmonary tuberculosis much further study will be necessary before the exact indications are clarified. In our opinion both the immediate toxic effects, although they do not often appear to be severe, and the possibility of persistent equilibratory disturbance, or even more serious late toxic sequelae, makes it unjustifiable to treat any patients except those who are senously threatened This excludes all cases of minimal pulmonary tuberculosis the prognosis of which with adequate rest treatment is almost always favorable. In more advanced cases the outlook for favorable response to streptomycin is best when the disease is of recent origin or early exudative lesions predominate. In those of longer duration with more established secondary changes, the possibility of a sufficiently favorable effect to contribute importantly to recovery is by no means excluded, but it is less regularly to be anticipated In general however the outlook for recovery with standard treatment must be carefully evaluated, and streptomycan had best be witheld if this is favorable. The apparent correlation between in vitro sensitivity and clinical course observed in the majority of patients of the present study, is perhaps not numerically sufficient to be regarded yet as the general rule Assuming however, that it will be confirmed it is evident that where neither strep tomyein alone nor standard treatment alone may be expected to control the disease, the combined use of streptomyein and collapse therapy will have to be worked out carefully with respect to dosage, duration of course or courses and timing. If as now seems probable the period of effective antibacterial therapy is limited to approximately two months in most instances, it is important that the course of streptomyein not be given prematurely and that surgery when it is necessary not be unduly delayed beyond the period of maximum benefit from the antibacterial therapy.

It should also be mentioned here that there is no evidence that relapse following streptomycin therapy is any less likely than following rest therapy alone. Prolonged rest treatment after, as well as in conjunction with, streptomycin seems therefore just as important in these as in any other patients treated for pulmonary tuber culosis.

It cannot be overemphasized that the streptomycin treatment of pulmonary tuberculosis is still in its early experimental phase. The drug should, therefore be given only with detailed knowledge of the possible toxic effects and with careful observation for early detection of poten tially serious manifestations. The treatment should usually, therefore, be given in a hospital where routine audiometric and renal function tests frequent blood counts, and bacteriologic studies can be adequately and easily made Its indiscriminate use in improperly selected cases and without the necessary safeguards of these special examinations can lead only to harm and to delay in establishing its correct place in the therapy of tuberculosis.

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Discussion

Nicholas D D'Esopo, M.D., Summount—Probably the most important problem in the streptomycan therapy of pulmonary tuberculosis at the present time is the fact that the bacilli of the major ity of treated patients acquire the ability to grow in high concentrations of streptomycin concentrations of the drug that are far greater than can be obtained in the circulating blood without scrous toricity. A group of 25 patients recently studied at Summount revealed that 30 per cent had acquired in vitro resist ance to streptomycin at the end of one month and 60 per cent had acquired resistance at the end of four months. Such adaptability on the part of the bacillus appears to be a disadvantage to the patient.

In the Sunmount group there was a rather definite correlation between resistance to the drug and the clinical responce to the drug. On the whole, patients whose organisms had become resistant did poorly as evidenced by symptomate sputning.

amount, bacillary content of the sputum, and the weight curve However, there was no spread of disease in these resistant patients, although the cavities of 5 resistant patients became larger during therapy. This phenomenom, the enlargement of cavity during treatment, was not observed in patients whose organisms remained susceptible to streptomycin. There was also a relationship between the time at which enlargement of cavity occurred and the time that resistance developed. We found this temporal relationship most interesting since the in vitro laboratory test that discloses resistance is by necessity delayed about two months.

Five patients who had been treated for one hundred twenty days and who had become resistant were retreated after an average interval period of forty-five days. Two became worse during treatment, and one of these died of a massive hemorrhage. Of the other three, one showed a further increase in cavity size, and two patients showed a reduction in cavity size. These latter two cases suggest that after cessation of therapy a greater proportion of bacilli may become susceptible to streptomyon However, the present in vitro method of testing resistance does not measure the proportions of susceptible and resistant bacilli

It is probably true that not all of a patient's bacıllı become resistant to streptomycin at the same time. It happens, therefore, that some patients will continue to improve or at least do not become worse during treatment, although their bacilli are pre-dominantly resistant to streptomycin in vitro. This mus loccur because an appreciable proportion of the total number of bacilli are still susceptible, and the suppression of this susceptible proportion is sufficient to effect a favorable therapeutic response other hand, there are probably some patients whose natural immunity is so low that almost all bacilli must be suppressed for improvement to occur When the bacilli of such patients become resistant, relapses will be seen during therapy Therefore, the number of relapses during therapy in any group of treated patients will be related to the types of patients selected. Dr Muschenheim's group of patients were, for example, far more advanced on the whole than the group studied at Sunmount

understandable that a certain number of relapses during therapy should have occurred.

Dr Muschenheim and his associates have suggested that the optimum period of treatment is In general, I would agree about six to eight weeks with this There are two observations that make us believe that this is a reasonable course to follow First, the majority of patients develop resistance to streptomycin and after that respond poorly to the drug Second, streptomycin in pulmonary tuberculosis does not appear to be definitive therapy and in most cases will be useful as an adjunct to established collapse procedures At the present time the preparation of patients for collapse therapy during the early months of treatment when bacilli are still predominantly susceptible would seem to be a sound method for using the drug. It is probably not wise to employ streptomycin in types of pulmonary tuberculosis that can be controlled by conventional therapy

We must still learn whether resistance to streptomycin is permanent. If it is permanent we must not make favorable cases resistant, since such cases may require streptomycin during an acute relapse in the future.

There are variations in therapy still to be studied Intermittent streptomycin therapy must be explored in the hope that the development of resistance might be delayed. Small doses, such as 1/2 Gm daily, should be tried in the hope that such doses might result in fewer resistant cases. The almost incredible therapeutic response to streptomycin in the early months of treatment should not make us unduly optimistic, nor should we be discouraged by the disappointing phenomenon of resistance. As it stands now, streptomycin is a valuable adjunct to the treatment of pulmonary tuberculosis.

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STREPTOMYCIN CURE OF PLAGUE REPORTED IN INDIA

Streptomycin cure of plague was reported by General Sir Sahib Singh Sokhey, director of the Haffkine Institute in Bombay

In experimental tests with plague-infected mice, streptomy cin treatment resulted in 100 per cent cures. When 87 human patients with bubonic plague, including 15 in an advanced, usually fatal

stage of the disease, were given streptomycin treatment, all but two recovered

The streptomycin used in these studies and to treat the patients was donated by Dr Robert D Coghill of Abbott Laboratories, North Chicago, Ill, and the British Medical Research Council.—Science News Letter, February 21, 1948

DIAGNOSTIC DIFFICULTIES IN INTRATHORACIC NEOPLASMS

JOHN L POOL, M D New York City

(From the Thoracic Surgical Service, Memorial Hospital)

A DIAGNOSTIC study of patients with breathing or swallowing complaints necessitates the considered use of various adjuvant diagnostic equipment. It is my plan to present briefly the methods now used at Memorial Hospital to arrive at an accurate evaluation of a given patient's problem in the field of intrathoracic disease. It is too large an order to discuss all the intrathoracic phases of neoplastic disease. I wish simply to review with you the step-by-step procedures which aid in the differential diagnosis of tumors within the chest.

The history is often of prime importance in pointing to further investigative steps. esophageal cancer, for instance there is almost invariably a rapidly increasing dysphagia extending over a period of at least two months. There is seldom an antecedent history of swallowing difficulty, although I recently saw a fifty-year-old woman who gave a fifteen year history of 'food sticking in the throat' and the fear of swallowing the wrong way Because of this fear she gave up all meat three years ago, but rapidly progressive dysphagia only developed six months before she sought medical advice. She had an annular carcinoma just below the cricopharyngeus which was proved by endoscopic biopay, plus evidences of a long-standing Plummer-Vinson syndrome

The most prominent symptom in patients later proved to have bronchogenic carcinoma has been a continuing cough. This symptom has been present in 95 per cent of some 600 patients with this disease recently reviewed by LaDue and Craver at Memorial Hospital and has been the first symptom in three fourths of the patients 1 The cough has no characteristic different from cough due to tracheobronchial inflammation and may or may not be associated with expectoration Pain has frequently been mentioned as a promi nent symptom of lung cancer, and this is true of those lessons which are extensive or where there is invarion of mediastinum or visceral pleura Nevertheless, pain is frequently absent in early stages of bronchogenic carcinoma, that is, when intensive surgical or radiotherapeutic measures stand a chance of arresting the disease Hemoptyais of some degree, varying all the way from slight spotting to frank hemorrhage, occurs in most patients with lung cancer except in such perpheral lesions as those in the superior pul-

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, Secalon on Chest Diresses, May 8, 1947 monary sulcus. The bleeding is in no way different from that seen in pulmonary tuberculosis. There is, in short no characteristic history to differentiate primary lung cancer from other lung disease.

Physical examination will tell the examiner where portions of lung are consolidated, atelectatic, or emphysematous, The presence of pleural effusion and metastatic cancer-enlarged lymph nodes in the supraclavicular or axillary groups may be detected Clubbing of the fingers is observed in those cases where pneumonitis accompanies the neoplasm, particularly where there is pulmonary infection in relatively airless lung pempheral to an endobronchial lesion Wheezing or persistent rhonchiover one area of the chest is always suggestive evidence of partial bronchial obstruction, especially when the ex piratory phase is prolonged. If present on reneated examinations growth rather than a mucous plug should be considered the blocking agent Tumor masses in the mediastinum may lead to blockage of the superior thoracic inlet with engorgement of chest, neck, and arm voins, and with facial edema.

The most important laboratory aid is, of course, the x ray For lung and mediastinal diagnoses, the PA chest film at 6-foot distance, plus a lateral taken at the same time, are the most useful views. A PA film alone can be deceptive For instance, a spherical density lying in the paravertebral area nine times out of ten will be a tumor of neurogenio origin, whereas a spherical mass of homogenous density adjacent to a lung hilum is highly suspicious of bronchogenic cyst. These could not be differentiated on the PA film alone

When evaluating shadows within the mediastinum, it is important to determine whether they he anterior or posterior and their relationship to the cardine shadow, to the diaphragm to the trachea, and to the esophagus For this purpose fluoroscopy is most useful. It also affords an opportunity to determine whether there is ex pansile pulsation or merely transmitted pulsa tion. Furthermore, fluoroscopy can be used to determine whether a specific shadow will separate from the diaphragm on deep inspiration. It is often helpful to give a swallow of thick barium to illuminate extrinsic or intrinsic esophageal compression, even though the patient may have no complaint referable to awallowing Posterior mediastinal shadows require films with the Bucky technic for bone detail, because the ganglioneuroma is apt to produce deformity of the rib margin by pressure, and some of the neurofibromas have dumbbell extension through the vertebral foramina. Tumor masses about the cardiac shadow and the aortic arch at times will require differentiation from aneury sm by angiocardiography.

X-ray diagnosis of secondary lesions within the lung parenchyma is relatively easy where such The solitary metastasis lesions are multiple from asymptomatic and unrecognized primary carcinoma elsewhere may be impossible to differentiate from primary lung cancer on x-ray Such secondaries have been seen examination from the thyroid, the rectum, and the kidney Tomography or sectional x-rays of the lung prove helpful in determining the presence of cavitation within atelectatic tissue and, also, at times delineate endobronchial tumor masses 2 However, they cannot tell you definitely whether such an endobronchial protrusion is an adenoma, a bronchogenic carcinoma, or inspissated mucus 2 Bronchography also is useful in localizing obstruction, deformity, and distortion of branch bronchi 3

Almost all esophageal lesions are readily diagnosed on the esophagram as filling defects or Nevertheless, there are certain benigh ulcerations with associated stricture which cannot be differentiated by x-ray examination alone In a sixty-nine-year-old man, complaining of a six-month dysphagia, continuous epigastric pain for three months, and a thirty-pound weight loss, esophagoscopy revealed stricture of the lower third of the esophagus Biopsy showed inflammatory ulceration on gastric mucosa Since the x-ray picture could not rule out carcinoma in his intrathoracic gastric segment, for he had a definite, congenitally short esophagus, exploratory thoracotomy was carried out, and formal biopsy confirmed the diagnosis of peptic ulcera-

Histologic proof of the presence of cancer is the prime goal in diagnostic study before decision as to therapeutic measures can be made. This is relatively easy to achieve in esophageal cancer through the use of the esophagoscope. The occasional case will have submucous extension of disease as the presenting endoscopic finding so that biopsy of the actual ulcer with a biting forceps is not possible. In such cases a fine cupshaped curet can secure tissue for microscopic study. The seeking of biopsy through the bronchoscope is another matter ⁴ In reviewing 14 patients with lung cancer at Memorial Hospital, it was found that bronchoscopy was completely negative in 21 per cent, there was visual

evidence of extrinsic distortion of the bronchus

consistent with cancer in 12 4 per cent, and visual,

although not microscopic, evidence of endbronchial cancer in 29 8 per cent Routine microscopic diagnosis was achieved in 37 per cent As 65 per cent of primary bronchogenic carcinomas arise in the major bronchi, it is a little disappoining that less than half of all bronchoscopies have yielded positive diagnoses under the microscope

The value of bronchoscopy has been enhanced recently by the suggestion of Dr Clerf, wherein I or 2 cc of saline is instilled into the suspected segmental bronchus, the return fluid aspirated, spun down, and studied under the microscope, preferably by the method of Dr Papanicolaou 16 This method is particularly applicable in patients where hemoptysis is a prime finding and with lesions in the midpulmonary zone We have alo had considerable satisfaction from Dr Papanicolaou's help in examining expectorated sputum In 50 patients in whom lung for cancer cells cancer was corroborated by histologic studies, he found neoplastic cells in the sputum of 78 per cent and no such cells in 22 per cent No patient in our series to my knowledge has been diagnoed as having lung cancer on sputum examination where the diagnosis was not subsequently con-

In those patients where there is a peripheral x-ray density suggestive of lung cancer and where bronchoscopy and sputum examinations have not confirmed the clinical impression, aspiration biopsy has frequently clinched the diagnosis 7 In a group of such patients where this diagnostic method was employed, failure to secure a positive diagnosis resulted in 154 per cent, while in \$4.6 per cent cancer cells were Of the latter, half showed microscopic characteristics of lung cancer on the sections cut The others from the plug of tissue removed could simply be diagnosed as cancer, type unde-I should like to emphasize that this termined procedure is done under fluoroscopic guidance, with the patient in a recumbent position to avoid the danger of air embolism An 18 or 19 gage needle with a short bevel and an obturator, which is not removed until the needle tip is within the area of increased pulmonary density, is employed In the past year there were 2 complications in 63 cases One patient with an emphysematous lung developed pneumothora, and another had one hemoptysis of approximately 75 cc immediately Both promptly refollowing the procedure Both prompus covered There has been no evidence of infection or tumor growth along the needle tract In those patients where pus is encountered on aspiration, penicillin is instilled

There remains, finally, despite the use of the above diagnostic methods, a small percentage of patients in whom a definite diagnosis cannot be reached, and this group is frequently that most

important one, the people with early and presumably more operable lung cancers. For them exploratory theracetomy is available as a diagnostic procedure. At the time of such exploration, the situation may be clarified by performing aspiration blops on the intratheracle mass. For mediastinal tumors, which are frequently chance x ray findings and which may be situated in such positions that aspiration biopsy is unsafe due to the adjacency of large vessels, exploratory theracetomy is indicated as is illustrated by the following case

Case Reports

Case 1 -- E. C., a fifty nine-year-old oil refinery workman, had an opacity noted in the antenor mediastinum overlying the cardiac shadow during a tuberculosis survey at this plant. He was asymptomatic until told of this lesion and then became conscious of sticking pains in his left anterior chest. Fluoroscopy revealed no pulsation vital capacity was 3 L. venous pressure was 180 cm, water in the left arm circulation time arm to tongue decholin, 10 seconds and arm to lung, other 7 seconds The lesion was observed for two months without change Exploratory thoracotomy was advised for diagnostic purposes and was carried out on February 25 1947 A fixed, hard mass, approxi mately 12 cm. in diameter was encountered in the anterior mediastinum. Aspiration biopsy was car ried out under direct vision and the diagnosis of carcinoma possibly epidermoid was returned With this knowledge the mass was totally extir pated with the adherent left mediastinal pleura and a considerable amount of mediastinal fat tissue adherent to the ill defined periphery of the tumor The anatomic setting was that of the thymus gland and the final microscopic diagnosis was thymic carcinoma.

In conclusion, I should like to present the case histories of 3 other patients illustrating some of the steps in the diagnosis of lung cancer which we have been discussing

Case 2 -A. B a fifty two-year-old automobile mechanic applied at the Thoracic Surgical Clinic on June 26, 1946 complaining of a one-year morning cough with small amounts of yellow expectoration Two and one-half months previously there had been a febrile episode the temperature going to 104 F with chills and dyspnea, diagnosed as pleurisv without x ray examination and improving after twolve days of chemotherapy although the cough productive of increased amounts of yellowish sputum, occasionally tinged with blood persisted One month prior to admission the patient felt weak and stopped working On physical examination the findings were limited to the right chest where an area of atclectasis was thought to exist just below the right clavicle. This finding was confirmed on PA and right lateral x rays Bronchoscopy on July 1 revealed copious drainage of pus from the

right upper lobe bronchus whose orifice was reddened and edomatous Examination of this pus by Dr Papanicolaou was not conclusive. A few days later an aspiration blops, through the right second interspace 6 cm to the right of the midline encountered an abscess containing 15 cc. of thick pus at a depth of 5 cm. One hundred thousand units of panicillin was instilled. The patient felt im proved and the temperature no longer rose above 99 4 F Because of the continued expectoration of 30 to 50 cc. of pus daily bronchoscopy was re-peated on July 27 at which time a granular area was noted in the entrance to the right upper lobe bronchus Biopsy rovealed bronchogenic carcinoma. Aright pneumonecotomy was successfully performed The specimen showed multiple abscesses in the right upper lobe behind a carcinoma arising in the main bronchus of the right upper lobe tion biopsy in this case and sputum examination were not diagnostic of the underlying pathology whereas repeated bronchoscopic examination was

Case 3 -W I a sixty three-year-old shoe repair man applied at the Thoracic Surgical Clinic on January 1 1947 complaining of a 20-pound weight loss in five months and six weeks recurrent hemoptysis of bright red blood. He had smoked over a package of eigarettes a day for many years and had a chronic nonproductive cough the character of which had shown no recent change. Physical examination revealed a somewhat emphysematous chest with persistent, moist coarse and fine rales just below the angle of the right scapula. The patient was febrile \int_-ray examination showed a rather homogenous density in this area. Bronchoscopy on January 6 was negative until the right lateral basal branch bronchuse was irrigated with two ce of saline. The return was bloody and, on staining by Dr Papanicalaou numerous neoplastic cells were seen On January 27 a right pneumonectomy was performed without further diagnostic study of the primary lesion, and the specimen revealed centrally necrotic epidermoid carcinoma of the right lower lung with an almost croded vein freely traversing the cavity

Case 4 — L. R., a forty-seven-year-old furrier applied at the hospital because of three months increasing fatigue and a nonproductive cough. He was referred to the Thoracic Surgical Clinic with a spherical peripheral density in the right midchest. Sputum studies and bronchoscopy did not reveal carcinoma. Aspiration blopsy produced a smear in which numerous neoplastic cells were seen and on pneumonactomy a bronchogenic carcinoma, Grade III was removed.

Conclusion

An effort has been made to summarise the methods available for reaching a diagnosis when intrathoracic neoplasm is suspected Particular emphasis has been laid on the importance of histologic proof Satisfactory tisue for microscopic study can be secured from sputum, from bronchial irrigation by endoscopic biopsy by aspiration blopsy or by thoracotomy Definitive

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treatment of intrathoracic neoplasms rests on knowledge of the basic pathology in each patient 444 East 68th Street

Discussion

Stewart, M.D., Buffalo -Dr Pool's Tohn D subject is a particularly timely one, for with modern advances in chest surgery, many previously hopeless lesions of the chest have become amenable to surgical operation Furthermore, with the growing use of chest x-ray survey of civilian groups and the routine chest x-ray on admission to hospitals, more and more early and silent lesions are being presented to the chest physician for definitive diagnosis and treatment

We are all especially interested in the early diagnosis of bronchogenic carcinoma Besides the points which Dr Pool has mentioned, I should like to stress the symptom of change in character of cough or sputum as being an early clue to the onset of bronchogenic carcinoma In these days of dust, fumes, and abuse of nicotine many individuals have a cough for years However, should the sputum become more abundant, tinged with blood, more difficult to raise, or mucopurulent, investigation is Just as change in bowel habit may mark the development of cancer of the colon or rectum, so may change in cough habit usher in the early clinical picture of bronchogenic cancer

With respect to the x-ray findings, which are allimportant in the detection of bronchogenic carcinoma, it should be emphasized that the goal of the clinician is early diagnosis. The tumor may be revealed by its obstructive phenomena before the mass itself is apparent Lobar or lobular atelectasis, segmental pneumonitis, trapping of air, and obstructive emphysema may comprise very suggestive evidence of the presence of bronchial obstruction

I agree with Dr Pool that exploratory thoracotomy is often indicated in a doubtful diagnostic problem, and I am inclined to think that I probably use this method in many instances where he would perform aspiration biopsy. The latter procedure does not appeal to me for reasons he has mentioned in his discussion. On the other hand, aspiration biopsy at the time of thoracotomy is sometimes essential, but here it is a safer procedure, and definitive treatment follows immediately

Dr Pool is quite right in minimizing the importance of pain as a symptom of intrathoracic tumor It is still a common and tragic mistake on the part of patient and even physician to procrastinate because the lesion is not painful Successful surgical treatment in this field, as in gastrointestinal cancer and cancer of the breast, depends less, probably, on the surgeon's technical virtuosity than on his having a favorable case on which to operate

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DOCTORS' DEATH RATE LEADS IN PROFESSIONS

Mortality among physicians is higher than among most other professional groups, Dr Louis I Dublin, second vice-president and statistician of the Metropolitan Life Insurance Company, said at a recent meeting of the Medical Society of Kings County

Although the death rate among doctors is unfavorable in comparison with other professional classes, it is not higher, for physicians of all ages, than the level of the general population, Dr Dublin He said the death rate among physicians was lowest in the west north central states and highest in the southeastern states

The death rates of physicians are lower than those of white men in the general population at ages under 45, but at the higher ages there is little difference between the two groups, according to Dr

Dublin He said the leading causes of death among men physicians were diseases of the heart, cancer, nephritis, pneumonia, influenza, and accidents

Physicians have higher death rates from degenerative conditions than the general population, but much lower death rates from most infectious diseases, Dr Dublin explained For cancer, appendicitis, hernia, and intestinal obstruction, the death rates among physicians are about one fourth below those of white men in the general population, he added

Dr Dublin gave the life expectancy for men physicians at the age of 25 as 43 8 years, at the age of 45 as 25 7 years and at 65 as 12 years He said these figures differed little from those for white men generally

DIAGNOSIS AND TREATMENT OF MINIMAL TUBERCULOSIS

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THE importance of making an early diagnosis L of tuberculous has been brought to mind forcefully many times during the past few years Mikel and Plunkett have indicated a definite upward trend in the percentage of gunimal lesions diagnosed in recent years in upstate New York apparently due, at least partly to the effective screening of applicants for service in the armed forces during the late war 1 As a military problem, it has received considerable attention, and Long in his excellent review of the subject has compared tuberculosis rates of previous wars with the incidence in the late war ! Many of the procedures adopted for detection and exclusion of tuberculous individuals from military service might well form a pattern for the detection and exclusion of tuberculous individuals from our civilian population.

In striving for a higher percentage of diagnoses of minimal lesions, we should not be too dismayed if the ratio rises slowly Tuberculosis is a disease of varied manufestations ranging from the explosive pneumonic types to the slowly developing insidious asymptomatic forms. The former may present diagnostic difficulties for a short time, due to seventy of symptoms, location of lesion, etc., but usually the diagnosis can be established by the clinical course, presence of tubercle bacilli in sputum, and other diagnostic measures. Many cases in the latter category do not come under observation until late in the disease, since they are asymptomatic or nearly so On examination, the time honored stress on general physical habitus, differences in shape of thoracic cage and physical signs of palpation percussion, and auscultation are too often unfruntful even with a history of tuberculosis in the Perhaps the modern physician is not as adept in physical diagnosis as the physician of years ago, or perhaps the stress and strain of a busy practice precludes the time-consuming use of many physical tests. At any rate the physical findings in minimal lesions may be, and often are within normal range.

During World War II the armed services depended almost entirely on the roentgen ray in some form. Conventional x-rays were taken, but screening was done almost exclusively by photoroentgenography, utilizing 4 by 5 inch plates and

35 mm film Similar screening was conducted by other armed forces, notably the British German, and Canadian. The results varied somewhat, but aside from the Germans approximately 1 per cent of the males of inductible age were found unfit for military service. As a result of this screening total admission and discharge rates for tuberculosis in the U.S. Army in World War II were approximately one-tenth of

those prevailing in World War I

Possibly the time is not ripe when such x ray surveys can be applied to the civilian population as a whole. However, many communities are profiting from military experience Healthauthor ities, tuberculosis associations and physicians in general realize that early diagnosis in tuber culosis is not only a matter of extreme care, using adequate diagnostic methods in clinic, hospital, and office but also a matter of suitable organisation whereby groups of the population may be x rayed en masse Several population groups provide a high tuberculosis incidence. and on these groups our present efforts should be concentrated In one year's operation the Mobile Unit of the Buffalo and Erie County Tuberculous Association surveyed 81 253 in neighborhood, educational, mercantile, and industrial groups, using 70 mm. film. Two hundred ninety four persons were found to have significant pulmonary lesions. These, with few exceptions, were unknown to family physician. health authorities, or the patients themselves Clearly then from military and civilian experience the diagnosis of minimal lesions must not await the patient's visit to physician or clinic Rather we should seek out the lesson wherever and whenever we have the opportunity

Certain professional and industrial groups present definite occupational hazards. Students of nursing, particularly in hospitals having wards for the care of tuberculous patients, medical students, interns and residents, other hospital personnel such as aides ward helpers, and laboratory technicians and industrial workers particularly in heavy industry or one in which dust hazard may exist, are among these.

The last few years has brought a keen appreciation of the problem in nurses training schools and medical colleges. It is generally agreed that young women entering training without evidence of primary infection (about 80 per cent of the total) constitute the major problem

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In hospitals where tuberculous patients are treated, the infection incidence rises sharply In our own experience at the E J Meyer Memonal Hospital, 90 to 100 per cent are positive reactors to old tuberculin on graduation, and nurses developing active reinfection tuberculosis, with very few exceptions, belong to the negative reactor group on admission The need for evtreme vigilance in this group is imperative Close interval tuberculin tests, chest x-rays, sharp scrutiny of prolonged "colds," and prompt diagnostic procedures on those individuals presenting erythema nodosum are essentials Similar control measures should be carried out for medical students, interns, residents, and all other hospital personnel engaged in the observa-

tion, treatment, and care of the tuberculous

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The x-raying of industrial workers has increased considerably for two main reasons first, compensation laws make selection of workers free of pulmonary disease almost imperative, and second, the experience of the armed forces focused the attention of industrial physicians, executives, and labor leaders on this Employment applicants are found to have significant pulmonary lesions by x-ray in approximately the same proportion as were found in the induction centers. It may be argued that many of these lessons are actually healed lesions However, proof of stability cannot be determined with certainty without further observation and diagnostic procedures Although sometimes an apparent disadvantage to the worker, it is obviously desirable that an evaluation be made where any question of lesion activity exists. The advantages of such a program to the healthy workers hardly needs Regardless of the type of mechanics used, the cost of pre-employment examinations. including v-rays, is not great

Racial groups should receive special attention Surveys have indicated that morbidity from tuberculosis is not much greater in the Negro population than in the white population groups ³ Nevertheless, the prevalence of acute, fulminating types with short, fatal illnesses, raising the Negro death rate in most of our northern cities four to eight times that of the white population, is known to all chest clinicians. Therefore, the need for early diagnosis is urgent and can only be accomplished when there is an opportunity to survey large portions of this racial group, as often and extensively as possible

Family groups in which tuberculosis is known to exist should be specially scrutinized. The spread of lesions among family contacts is known to every physician and health officer. Most families are complex units exhibiting characteristics and traits for generations. The high

morbidity and death rate in certain families, as compared to other families living under similar conditions, would seem to indicate a hereditary susceptibility to the disease ^{4 5} Further intensive study of interrelated families living under similar hygienic conditions may yield important data

The large percentage of persons in hospitals for the mentally ill having significant pulmonary tuberculosis constitutes a problem concerning the other patients, the personnel, and parole possibilities ⁶

Thus, we may suspect tuberculosis and should attempt to survey the aforementioned groups closely Hospitals and clinics can contribute much to mass survey methods by adopting as routine the procedure of x-raying the chest of every new admission In addition to uncovering unsuspected tuberculosis, other valuable data relating to neoplasms, bronchiectasis, cystic disease of lungs, and cardiovascular conditions can be obtained This routine is becoming increasingly popular and will soon be, I am sure, as commonly practiced as routine urinalyses and blood counts The increasing use of hospital facilities for the care of the sick will result in a greater proportion of the citizenry having lung roentgen ray surveys

However, the diagnostic burden for a large proportion of the population will rest on the attending physician who, in order to diagnose early tuberculosis, must suspect it After a collection of careful historical data, suspicion may be aroused by certain outstanding "first" symptoms, those symptoms which prompt the patient to seek and Hemoptysis is the most dramatic of these, and tuberculosis is most commonly responsible Chest pain, often aggravated by cough or deep inspiration, is very significant and must be seriously investigated pleural effusion exists, diagnostic thoracentesis may be done for culture and gumea-pig inocula-In the absence of other cause for effusion, a negative culture or failure to infect the guinea pig should not deter one from diagnosing tuberculosis Mantoux test, x-rays, sedimentation rate, blood counts, and clinical course all aid in Hoarseness, intermittent in nature and without pain, may be significant, and careful diagnostic survey should follow Occasionally. a remote lesion such as ischiorectal abscess or scrotal swellings or sinuses may be the "first' symptom or sign Certainly a minority of ischiorectal abscesses are tuberculous, but the percentage which are justifies a tuberculosis survey in all cases Other cases have their onset in a pneumonic state and present rather typical symptoms of pneumonia Sputum studies, blood counts, lack of response to sulfonamides or antibiotics, and clinical course soon lead to the proper diagnosis

The foregoing symptoms are more or less dramatic in nature and represent chiefly rapidly developing lesions Otherwise medical aid may be sought for what seems to be a protracted cold sometimes with dry hacking cough general rundown" feeling a malaise or lassitude. necessitating forced drive to carry on duties, loss of appetite vague dyspentic symptoms feeling of apprehension, alteration of menstrual function, and rarely night sweats occurring early in the disease. The multitudinous details of a good physical examination or the variety of possible findings need not be dealt with here except to say that a careful physical survey should be done As stated earlier in minimal lesions this may be entirely negative. In any case presenting any tuberculous possibility. I believe an x ray or photoroentgenogram is indicated at once. Sputum studies, blood counts, sedimentation rates and tuberculin tests made before roentgenography loses much valuable time and develops a sense of apprehension in the patient. In the great majority of patients x ray will provide definite positive or negative evidence of intrapulmonari disease Stereoscopie lateral oblique, and planogram views may be necessary in a few cases

After x raying the use of the tuberculin test should not be overlooked, especially in children and adults where the character of the lesson may be disputable. In the latter a positive reaction means little, but a negative reaction indicates the lesion as probably being nontuberculous

Sputum studies should be made on all suspected patients. If sputum is not obtainable for example, from those who do not cough or raise or from children gastric lavage with sediment culture and/or guinea-pig inoculation may clinch the diagnosis.

Sedimentation rate is a valuable diagnostic and prognostic procedure. It must be romembered that a few active tuberculous lesions will produce normal values. A high value suggests activity of the lesion.

In active lesions the white blood count is usually normal or slightly increased with differential shift to left. Increased monocytes denote activity, and increased lymphocytes usually indicate a healing lesion

Bronchoscopy may be used in controversial cases and in those whose symptoms or physical signs indicate the possibility of an associated endobronchial lesion

By combining all the evidence a diagnosis and state of activity can usually be evaluated Many of the lesions seen by x ray in hospital or field surveys must be carefully considered. To

diagnose small, well-scarred, or calcific lesions commonly seen in the upper lung fields as minimal tuberculosis, and to report them at once to health authorities is, I think adding a burden to already overworked personnel and doing the patient an injustice. The collection of all available evidence and continued observation over a period of six months to two years or more is often necessary to evaluate accurately the activity status in many of these cases.

Small, calcified areas elsewhere in lungs with associated calcific deposits in hilar glands do not present such a problem. One can assume more definitely the existence of a primary lesion well healed or the end result of some other previous infection such as histoplasmosis.

Treatment of Minimal Tuberculosis

I do not believe the treatment of any type of tuberculosis is complete without attention to prophylaxis. Today, American hospitals with 16 000 000 admissions yearly have an opportunity to use roentgenograms to identify the tuberculous. Isolation measures can be effected rapidly, thereby protecting personnel. Industry can be encouraged to extend pre-employment evaminations to include the use of x rays, and public interest can be stimulated to a greater awareness of pulmonary disorders.

Data collected by workers in this country and abroad in studies of population groups heavily exposed to tuberculosis indicate that the use of BCG vaccine is practical 7-18 New York State has already developed plans for the production and use of this product through restricted channels. Much benefit can be expected by student nurses medical students, and other heavily exposed groups, as well as members of family groups in contact with open cases. Its use would seem particularly applicable to young, noninfected children exposed to tuberculosis. Available data indicates the vaccine affords 75 per cent protection no untoward reactions or fatalities having occurred with proper controls.

With the establishment of a definite diagnosis and activity of lesions the minimal tuberculous patient should be admitted to a sanatorium the chief reasons being first, segregation, regardless of whether he comes in contact with children or adults in his home second for continued observation and definitive therapy and third for education referable to the protection of others on discharge There are a few persons who, with adequate home environment and ways and means of obtaining care, will progress more favorably at home These are the few who react badly from a psychologic standpoint to separation from their families Mental rest must be achieved along with physical rest to obtain satisfactory results There seems to be no substitute for prolonged rest, and with a satisfactory dietary regime this will be adequate treatment for the majority of minimal cases No sanatorium program of less than six months should be considered adequate

If, in the course of a month or six weeks on strict bed rest, the patient shows no clinical improvement or shows actual progression of the lesion, artificial pneumothorax should be seriously Chincal evaluation will depend on considered the physical status, fever, tachycardia, comparative x-rays, sedimentation rates, and blood and sputum studies Graduated exercise may be allowed when all evidence to toxicity has disap-It may not be possible to follow this program because of fretfulness on the part of the patient or shortage of attendant personnel

It is too soon to state whether or not streptomycin will be of definite value in minimal tuber-Selected cases making poor response to rest therapy may provide an investigative field The choice between collapse and antibiotic therany must await further observation

From the beginning of the patient's hospital or sanatorium stay, a trained social worker may be of great value to the patient in acting as a liaison officer between him and the sphere he left through the patient's institution stay, the social worker may prove invaluable in cooperation with the medical and nursing services

As time goes on and the patient is making satisfactory progress with good response to exercise. occupational therapy may be added This need not always be in relation to his future occupation It may mean the later development of a good This may be considered rehabilitation which is, after all, the restoration of the patient to the fullest possible physical, mental, and economic status Many patients should not be required to learn new vocations The work for which they were trained will be most desirable to them on discharge and furthermore will yield the best possible economic situation for the cured patient Others will require definite vocational training before or after discharge In the mapority of instances. I believe this training can be conducted better by already existing schools and universities rather than by the individual sanatorum

Return from hospital or sanatorium does not mean that continuity of observation is over Interval studies and, in some cases, artificial pneumothorax should be carried out for a long time, in fact, I believe a periodic study at six- to twelve-month intervals for life is indicated When the patient, having a minimal lesion, is regarded as apparently cured, no particular restrictions need be placed on him except those of sane living, temperate habits, and avoidance of extremes in exercise, work, and play patient should not be regarded as a social outcast by himself or others It is not uncommon to see such a person succeed much better in a social and economic fashion than might be expected under normal conditions

333 LINWOOD AVENUE

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PHILADELPHIA COUNTY TO PRESENT ANNUAL POSTGRADUATE INSTITUTE

The Twelfth Annual Postgraduate Institute of the Philadelphia County Medical Society will be held at the Bellevue-Stratford Hotel, April 20 to 23, 1948 Due to the success of last year's program it is planned to present again the material in the form of a series of symposia on subjects of practical interest to the general practitioner and specialist.

Among the topics to be covered are problems in obstetrics and gynecology, newer drugs and procedures, surgery of the ambulatory patient, fractures, the painful breast, neuropsychiatric disorders, problems of the aged, the acute abdomen, gastrointestinal disorders, and otolaryngologic problems In addition to the regular morning and afternoon programs there also will be two evening sessions at

the Society Building on the subjects of cancer and pediatrics

The usual large number of technical exhibits will be important features of the sessions Registration fee for the entire meeting is five dollars the preliminary program and any further informa-tion may be secured by writing to Gilson Colby Engel, M.D., Director, 301 South 21st Street, Philadelphia 3, Pennsylvania

ISOLATED NONPENETRATING INJURIES OF THE PANCREAS

Ten Year Review of Literature and Report of a Case

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TRAUMA of the pancreas is a relatively rare condition. In 1907, Mayo Robson stated that up to then only 30 cases were recorded and only 8 of these represented isolated injuries. In 1923, Mocquot and Constantini collected 30 cases of isolated pancreatic injury from the literature up to that time in 100 000 consecutive admissions to the City Hospital. Welfare Island. New York, during the last eleven years, there was no case of trauma of the pancreas. Again, in a tem-year survey of the Cumulative Index we noted that 59 cases were reported. 38 in foreign language journals and 21 in those printed in English.

It would seem that isolated nonpenetrating trauma of the gland was the commonest form of injury. As near as could be estimated, there were 48 case reports in the literature during this ten-year period. It is very possible that others were met with but not reported, and it is quite likely that pancreatic trauma, occurring in connection with injuries to other viscera, was occasionally seen but was not considered of sufficient rarity to be reported. Perforating wounds, such as those from bullets and sharp pointed instruments, were decidedly less common with a total of 6 cases. Trauma, caused by the surgeon while operating on the pancreas or on some adjacent organ, was reported 5 times.

An analysis of the 21 articles written in English showed that 13 cases of isolated nonpenetrating injury of the pancreas were reported. The whole 13 were men and the causes of the injury were as follows in 2 cases the men were crushed between 2 trucks, in 2 the men were trampled in a fight, 2 fell off bleycles with 1 driving a flashlight into his abdomen and in 2 cases the patients, while playing, were kicked in the abdomen. One was run over by a truck, 1 ran into an unseen wire 1 had a heavy log fall on his abdomen. I was trampled by a horse, and 1 was injured in an underwater explosion during the war.

The degree of injury ranged from what was undoubtedly the contusion of a small area with minimal destruction of the tissues and minimal hemorrhage to a complete rupture with wide separation of the segments. The mildest case, reported by Jensen and Gill was that of a man who had a truck wheel run over his abdomen. He went into shock immediately and was rushed

to the hospital where he quickly responded to shock treatment. There was never any reason for an abdominal operation, and he was discharged three months after admission. While there was no positive proof that the pancreas was injured, hypergly cemia and glycosuma appeared during the acute stage and disappeared later From this and from the lack of any other sites of injury the authors inferred that the pancreas was contused

A somewhat similar case was reported by Adams in which a boy was kicked in the abdomen by a playmato. There were few signs until the fourth day when a severe, spasmodic abdominal pain set in There was no tenderness in the lower abdomen at first. Heavy glycosuria and a slight acetonuria were found. An exploratory operation found some fluid and fat necrosis in the peritoneal cavity. His recovery was uneventful.

The next group consists of those cases that have a minimal paneratic injury, as evaluated by their mild early symptoms with the later development of a secondary hemorrhage or a pseudocyst. A case was reported by Stevenson of a fity-eight-year old man who was trampled on by a horse. He called the doctor immediately, but the symptoms were mild for over a month, at which time the abdomen became distended. On operation a pseudocyst was encountered which was drained of four quarts of milky fluid.

A second case of this character was reported by Lahey and Lium. An eighteen year-old boy was kacked in the abdomen at football Three hours later, he began to complain of severe pain across the upper abdomen, he became nau seated and vomited He passed the first night comfortably, and felt well the following day, although he vomited in the afternoon third day, the pain returned He was admitted to the hospital where an operation was performed Although the pancreas was not visualized, a hemorrhage into the gastrocolic omentum from a ruptured pancreas was suspected. A drain was in troduced, and, shortly after the operation there was a copious discharge of pancreatic juice second operation to close the fistula was successful.

A slightly more severe pancreatic contusion was reported by Smith. A man was beaten at 3 A.M., and the assailants jumped on his abdomon several times after the attack. The ambulance was called at 4 PM, and the surgeon reported that the man had a slight pain in the abdomen but did not look seriously sick. The patient was brought to the hospital only because he requested it admittance he was found to be pale with a moderate tenderness in the epigastrium At 6 30 P M He slept through the first night and he vomited the second night On the third day, he complained of pain in the abdomen but the recti were found to be soft On the basis of a gradually rising leukocyte count reaching 14,950 on the third day. the surgeon decided to operate An abdominal opening was made sixty-six hours after the injury Free fluid was found in the lesser sac, the pancreas was large and boggy It was red in some areas, but there was no gross pancreatic rupture On the second postoperative day, the fasting blood sugar was 195 mg On the fifth day, it was The convalescence was otherwise uneventful, and a sugar tolerance test on the tlurtvfifth postoperative day was 65-173-103-73

The case reported by Armstrong was still more extensive 8 A man of forty-eight years was He collapsed im crushed between 2 trucks mediately and was removed to the hospital On arrival he was pale, sweating, and in severe The pulse was poor, and he complained of abdominal pains and tenderness on deep pal-In six hours, following shock treatment, For twenty-four hours, he had only he felt fine slight abdominal pains and slight tenderness in the right upper quadrant There was no rigidity The pulse had reached 120 after or dullness thirty-six hours Operation was decided upon The peritoneal cavity was found to be full of blood-stained fluid and areas of fat necrosis The pancreas was dark and large

The next group of injuries to the pancreas can be classified as those cases with laceration of the The first case reported by Halle was a man, fifty years old, who was trampled upon in a fight 9 He complained immediately of abdomi-He looked pale and had a rapid nal distress The abdomen was soft although it was tender He was comfortable all night and was in good condition all the next day On the third day, he vomited He stayed in bed eight days, on the tenth day a change came A blood count at that time showed 15,900 leukocytes operation was decided upon, and a large fluid sac was present in addition to scattered fat necrosis The head of the pancreas was markedly enlarged and revealed a laceration of 1 inch

Perhaps the next case in severity was that of Keynes ¹⁰ A British sailor, twenty-two years old, was in the water when a submerged explosion occurred. The man said he was not aware of any injury. On admittance to the hos-

pital he was very comfortable However, he soon showed signs of intraperitoneal hemorrhage and was operated on nineteen hours after the injury Considerable blood was found in the peritoneal cavity, but there was no evidence of any pancreatic damage. On the tenth day a pseudocyst appeared, and on the eleventh day there were signs of intestinal obstruction the second operation the lesser sac was tensely filled with fluid which had obliterated the foramen of Winslow and obstructed the colon vertical tear, 11/2 inches wide, was noticed in the middle of the body of the pancreas glycosuma was found, although the blood sugar was normal There was a slight increase in the fat in the feces for a time

The other case described by Keynes was that of a man of twenty who fell off a bicycle and drove a flashlight into his abdomen ¹⁰ An immediate operation was performed, and the pancreas was noted to be ruptured where the body of the organ was in contact with the spinal column. Three months later, the patient developed a pseudocyst

An early serious hemorrhage occurred in a case reported by Moulson, where the pancreas was markedly lacerated 11 A young man, half an hour after breakfast, ran into a wire, hitting his abdomen This was followed by acute colicky pains and some vomiting. His lower abdomen was soft on palpation He looked pale but was not in shock The abdominal pains were spasmodic, while the abdomen was noted to move normally with respiration In seventeen hours the pulse rate went up, and intermittent vomiting and colicky pains developed The upper abdomen was resistant By thirty hours the pulse was 120, and there was an obvious distention of the abdomen with definite dullness to percussion The urine was normal throughout

An emergency operation was performed at thirty-one hours, and a terrific hemorrhage became evident in the peritoneal cavity lesser sac which was coming through the foramen of Winslow was distended with blood search showed a large circular tear in the body of the pancreas, anteriorly The rent was partly closed by a purse string suture, but the surgeon stated that it was not complete as the friability of the tissue interfered On the tenth day, a pseudocyst appeared, and on the twenty-seventh day, the patient was operated on again twenty-ninth day, he had all the signs and symptoms of paralytic ileus This responded to treat-There was a complete absence of glycosuria throughout the hospitalization

A case with extensive contusion and laceration of the gland was reported by Jones ¹² A boy, eight years old, fell from a bicycle and injured his

abdomen In one hour he was in the hospital He did not vomit, and he was not nauseous. On examination he showed mild shock. There was moderate tenderness in the upper left quadrant without rigidity or evidence of a mass. A blood count then showed a leukocytosis of 15 000, and a short time later it was 23,000 He had a comfortable night. In the morning the white cells numbered 15,000 with 91 per cent polymorphonuclear leukocytes. The pulse had then come up to 160 At thirty-eight hours an operation was performed Fat necrosis was found and the pancreas was markedly contused with a rupture 2 inches in area, at the middle No sutures were The blood sugar and urine were normal throughout

There were 2 cases each of complete rupture and wide separation reported. The first was reported by Harrison and Cooper 13 A man of eighteen years had been injured seven months proviously by a heavy log falling on his abdomen For six weeks there were practically no symptoms At that time, however he noticed a swell ing in the abdomen that came and went entered the hospital after the accident, and a diag nosis of pancreatic pseudocyst was made abdomen was incised and the cyst drained first operation was unsuccessful, and a second was performed This showed the pancreas to be completely ruptured and the left half separated from the right but in communication with the cyst The distal end was removed It was thought by the authors that a hematoma was formed in mediately after the injury

The second case of complete rupture was reported by Curr 14 This was a man twenty years old, who had been pinned between 2 trucks The accident was not painful and he was able to walk after it occurred He went directly to the hospital There was no external evidence of trauma, and he was in only moderate shock. A urine test at that time was negative. Within four hours after his entrance his pulse went to 110 Also, by this time there was evidence of abdominal ngidity and tenderness. An oper ation was then performed, and a large amount of fresh blood was found in the peritoneal cavity No gastric contents were found The pancreas was split into two parts as though by a sharp The line of cleavage ran vertically almost exactly through the center of the organ parts had retracted with a gap of fully 2 inches between them, and the left half was lying entirely inferior to the base of the mesocolon geon inserted several deep matress sutures into each severed end, controlling the hemorrhage and closing off most of the raw surfaces Except for the occurrence of a fistula the recovery was uneventful. There was no evidence at any time of pancreatic deficiency or upset sugar metabolism.

We would like to report the following case which we have previously reported in part in a study of hypoglycemia. 14

Case Report

Case 1—Helen h. was admitted to the City Hospital, Welfare Island, New York, on March 11 1033 She was six and a half years old and had been struck by an auto the previous afternoon After the injury she was put to bed and had no complaints until the next morning when the pain started

On arrival at the hospital she looked acutely ill and complained of pain in her abdomen. The pain was radiating. She vomited at 4 r.x. and then became extremely thirsty but vomited very time she drank. Her abdomen showed rigidity over the entire area, and there was rebound tenderness. There was slight tenderness over the lumbar region which became marked in the left upper quadrant. The pulse was 84

A surgical consultant said he found moderate tenderness over the left lumbar region blood was found in the urine. The white blood count was 12 000 and the hemoglobin was 65 per The consultant did not think surgical inter ference necessary at that time He felt that there was a alight peritoneal irritation which might be due to a hemorrhage that was not extensive. At 12 30 A M the child was re-examined and the white cell count was 12,000 the red cell count, 3 000 000 and the hemoglobin, 65 per cent The urine showed no signs of sugar Rigidity was still present over the abdomen, most marked on the left side had risen from 84 to 132. The thirst and restlessness were still present. She vomited twice during the morning. Rigidity and thirst were present A blood count showed white cells numbering 53 000 red cells numbering 3 000 000 with hemoglobin of 60 per cent. The preoperative diagnosis was lacerated spleen.

The operation was performed by Dr A. S. Mor row at 5 P.M In the peritoneal cavity the omentum showed fat necrosis. About 1500 cc of a light wine-colored fluid was emptied from the cavity The splenic area was explored, and in the omentum some old blood was exuding from a rent splcen and liver were normal. The pancreas showed a vertical tear across the tall of the organ and a isgged opening about 3 5 cm. in width. A drain was inserted. The first three urmary specimens gave the following results for sugar negative 2 plus and 1 plus. The last test had acctone 2 plus. On May 19 1933 the blood sugar was 51 mg. On May 22 a sugar tolerance test was 118-75-83-73 and another on June 1 was 87-80-54-45-57 was discharged on June 8 1933 in good condition.

The patient returned to the hospital for a check up on February 18 1940 seven years after her discharge. She was then a well-developed healthy normal child of thirteen and a half years having been symptomless for the entire period. A sugar tolerance curve done then was 85-140-115-90-75. The outstanding thing about this case was that the hypogly cernla was not permanent.

Summary and Conclusions

We limited our survey to isolated nonpenetrating injuries of the pancreas, because we felt that in this way we would get an uncomplicated picture of pancreatic trauma While the term "isolated subcutaneous injury" is commonly used in the literature, we prefer the designation "isolated nonpenetrating injury," as we consider it more accurate

It is apparent that isolated nonpenetrating injuries of the pancreas are relatively rare, but they are probably the most common type of pancreatic injury encountered In such cases the force of the blow is transmitted through the intervening structures which have considerable "give" but expends itself on the relatively softer pancreatic tissue because the firm vertebral column stops its progress It has been mentioned, and it is evident in this series that most injuries to the pancreas occur in the middle of the body where it passes over the vertebra

Up to a short time ago, it was generally held that contusion or laceration of the viscus was All the cases reported here, however, recovered eventually with no permanent after-This was strongly indicated by our case report

Injuries vary in degree Mild cases occur with but small areas of parenchymal loss, slight hemorrhage, and only small ducts torn These heal spontaneously If the peritoneal covering of the gland is torn or seriously bruised, the blood usually passes through the rent and enters the lesser In most cases the blood is accompanied by pancreatic juice, exuding from a torn duct, which irritates the peritoneum causing chemical peritonitis with fat necrosis Some of the blood may pass through the foramen of Winslow into the greater peritoneal cavity with the same reactions In most cases the lining of the foramen becomes irritated, and adhesions follow which seal it up and provide the sac for the pseudocyst

Large lacerations may be produced were seen which were 2 inches in length, even complete severance of the gland can occur with wide separation of the segments The case of Harrison and Cooper, where the 2 parts of the gland were widely separated for over seven months with no apparent effect on digestion or sugar metabolism, is quite surprising 13

Hemorrhage was a common complication, and its extent and time of occurrence were important determining factors in the severity of the symptoms and in the necessity and urgency of In most of the cases there was evidence of small hemorrhages into the substance of the gland, or the lesser sac, or into both, and in a number of cases there were signs of secondary hemorrhage after varying periods of time lag In only 1 case was there a very extensive hemorrhage with enough blood lost to dominate picture

The diagnosis is difficult when one relie The serum am tirely on physical signs test, now considered very valuable, was no ported to have been made in any of the cas this series The presence of hyperglycem glycosuma in a nondiabetic is strongly sugge of pancreatic injury, and at times the presen a fistula excreting pancreatic juice may be only positive finding. The gradually i leukocyte count with the high polymorphonu fraction seemed to occur quite frequently when the other signs and symptoms were

The composite pattern of the cases taken the literature was remarkably similar to th the case we reported Following a severe tra of the abdomen, there was little or no shock dominal pain, or tenderness The patient have slept that night and the next one after one or more days, spasmodic pains b and the abdomen became only moderately te with slight or no rigidity. The white cell c usually rose, vomiting occurred only occaally, the pulse became rapid There migh signs of ilius, and evidences of internal her rhage and shock came later Shock therapy operation proved to be very successful, whi contrary to the present attitude in acute pan-

While an upset of the sugar metabolism curred occasionally, no rules for its pres could be formulated The finding of an questionable hypoglycemia in our case is hard to explain Also, there was only the sl est disturbance in 1 of the cases of the excre of pancreatic juice Finally, there was no dence that any permanent damage was dor the external or internal functions of the gl even in the most severe case The case we ported showed a perfect status after a very ınterval

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THE DIAGNOSIS OF SICKLE CELL ANEMIA

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Sickle cell anemia has been referred to as "the great manquerador" it is symptoma tology is so often suggestive of other diseases that it is easy to be led astray when symptoms point to other more familiar and more frequently observed conditions. It is not, however, as protean in its manifestations as Osler's "great imitator" syphilis, and, in general, cases of sickle cell anemia in children seem to fall into two main clinical syndromes.

The first type is that associated with the socalled abdominal crises Abdominal pain is the most constant and compelling symptom mild, such cases often go for a long time undiagnosed, being considered morely "belly-aches." or are wrongly diagnosed, being considered recurrent attacks of gastroenteritis or mesenteric adenitia Actually, the abdominal pain in this disease results from thromboses, usually small, mesenteric, but not uncommonly splenic, and the pain has the characteristic left upper quadrant localization. When the abdominal pain is severe, it may simulate an acute surgical abdom inal condition, and its localization largely determines the surrical condition it simulates. Campbell has shown the frequency and variability of abdominal symptoms in sickle cell anemia 3 reported several cases which were subjected to exploratory laparotomy with negative findings only to have sickle cell anemia diagnosed subsequently Surgical attack on a patient, undergoing an acute hemolytic process, may have a disastrous result. Cooley has described well such an unfortunate episode.*

The second type of sickle cell anemia is that associated with joint crises. These cases closely simulate acute rheumatic fever in many instances Indeed, patients with sickle cell anemia were long considered to be particularly susceptible to rheumatic fever until it became common knowl edge that the rheumatic like symptoms, as well as the cardiac findings, were an integral part of the sickle cell disease. It has since become apparent that true rheumatic infection is uncommon in sickle cell anemia, and as recently as 1942 Klinefelter stated that "there is no proved instance of the two occurring together 4 At least 2 cases however, of proved sickle cell anemia have shown unmistakable evidence of true rheumatic infection at autopey 4.4 The case of Walker and Murphy showed fresh verrucae on the heart valves and Aschoff bodies in the myo-

A typical instance of the closeness with cardium which sickle cell anemia can simulate rheumatic fever over a long period of time is dramatically illustrated by Hamman a case of a gurl presenting a typical rheumatic history and findings of poly arthritis with actual swelling of the joints and a progressive cardiac involvement, Several observers at the Johns Hopkins Hospital made independent diagnoses of extensive mitral and/ or acrtic disease Yet, autopsy revealed that the heart was essentially normal, except for moderate enlargement, and that there was no valvular damage or other evidence of remote or recent rheumatic infection. In reference to the joints themselves although pain is often severe, it is commonly held that the swelling and heat of the rheumatic joint are lacking. It has been our experience that actual heat and swelling of rhoumatic joints are rather uncommon at the present time, whereas in one of the cases to be described the heat and swelling were striking This then would appear to be an unreliable differ ential point

The occasional occurrence of sickle cell anema in a white person makes it necessary to include this for consideration in the disgnostic examination of any patient presenting agas of primary anemia obscure abdominal pain, or a rheumaticilike state. The following two cases which occurred by coincidence simultaneously in our pediatric ward are illustrative

Case Reports

Case 1 - Joseph C a 3-year-old white American boy of Italian-American parents was admitted to the hospital on January 31 1947 because of abdominal pain of one year's duration He had been well until one year prior to admission when he began to experi once intermittent abdominal pain, which was diffuse not localized, and usually not very severe. The attacks were unrelated to the taking of food or other gastrointestinal functions. There was occasional vomiting. The boy was seen frequently by his family physician who noted no particular abnormality One month prior to admission the pain recurred and another physician was consulted who noted a palpable spleen. Blood counts were per formed in an outside laboratory and those were said to be normal except for low hemoglobin,

The patient was referred to one of us (J B) for consultation. Moderate interus was noted in addition to the enlarged spicen and hospitalization was advised for diagnostic examination.

The patient is an only child, born of cesarean sec-

tion after the mother had lost her first two children during labor, due to a contracted pelvis—His birth weight was 6 pounds, 7 ounces, and his early growth and development were entirely normal—Feeding and vitamin prophylaxis were adequate—Routine immunizations had been administered—His only previous illnesses had been occasional colds and sore throats

The patient's mother is thirty-three, and was born in New York—She is one of 8 siblings, all living and well, without known anemia—One of her sisters had a son who died in 1933, at the age of seven, on his third admission for sickle cell anemia to the Brooklyn Jewish Hospital—As far as can be determined, this case has not been reported—The maternal grandparents were both natives of Calabria, Italy—The maternal grandfather died at the age of fifty-nine from "dropsy"—The maternal grandmother is alive and well at the age of seventy-five—She states that there has been no admixture of Negro blood in the family in her memory, and further, that Negroes are such a rarity in Calabria that she never remembers seeing one when she lived there as a child

The patient's father is thirty-nine and was born in Roccidinetta, Italy, in the same vicinity as his wife's parents The paternal grandparents are both dead, causes not definitely known, but both lived to advanced years The father is one of 6 siblings, one of whom (a sister) died at the age of five "from heart disease and anemia" This girl was not hospitalized and died at home The father knows of no other cases of anemia in his family The racial ancestry is identical with that of the patient's mother, and there is no known admixture of Negro blood Careful inquiry has been made by the parents of all living relatives

Sickling preparations were done on both the father and the mother Neither showed sickling

Physical examination showed that the temperature was 100 F, pulse 92, and respiration 22 The weight was 30 pounds General development and nutrition were normal The facies was not unusual, and there were no negroid features The skin showed a definite icteric pallor, and the sclera were visibly jaundiced The right ear drum was moderately inflamed. The tonsils were scarred and cryptic but not acutely inflamed There was no generalized adenopathy

The lungs were clear throughout — The heart was not enlarged, but a soft systolic murmur was audible in the mitral area — The abdomen was soft and not tender — The liver was not enlarged, but the spleen was definitely so and was easily palpated three fingers breadth below the left costal margin — It was firm, nontender, and had a sharp anterior border — The testes were incompletely descended — There were small subcutaneous ecchymoses about both hips and the right knee and calf

The skeletal system was negative for significant bony pathology on x-ray Teleoroentgenogram of the chest showed the lung fields to be clear, the cardiac configuration approached the upper limit of normal in size Flat plate of the abdomen demonstrated the enlarged spleen but was otherwise negative

The laboratory findings were as follows urmalyses, all findings within normal limits, admission blood count, 3,250,000 red blood cells, 7 9 Gm hemoglobin (52 per cent), 11,400 white blood cells A differential blood count yielded the following results neutrophils 70 per cent, lymphocytes 28 per cent, monocytes 1 per cent, eosinophils 1 per cent The stained smear showed marked anisocytosis of the red cells with poikylocytosis, central pallor, and numerous target cells

Sickling (wet preparation) was immediately positive (Fig. 1) This was repeatedly positive on several occasions

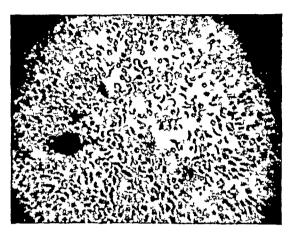


Fig 1 Photomicrograph of wet preparation of peripheral blood showing extensive sickling (Case 1)

There were 195,000 platelets, the venous clotting time was three minutes, twenty seconds. The patient's blood type was "A" International, the Kahn and Hinton tests were negative. The icterus index was 42.8. The results of the fragility test were as follows. Patient, hemolysis began at 0.38, complete at 0.30. Control, hemolysis began at 0.42, complete at 0.34.

The patient was given two whole blood transfusions of 250 cc each and was discharged on February 5, 1947, improved. He was seen again on March 22, 1947, and at this time he was generally well, and improvement had continued after leaving the hospital. The skin though still slightly interior had a good hemic component. The hemoglobin at this time was 14 2 Gm. The abdominal pain had recurred in mild form on 2 occasions, and there had been occasional vomiting. A repeat sickling preparation done at this time showed 80 per cent sickling after twenty-four hours.

Case 2—Bryon T, a 5-year-old Negro boy was admitted to the hospital on January 21, 1947, because of painful swelling of both elbows of eight days' duration—He had developed an upper respiratory infection about three weeks previously which had grown steadily worse in spite of bed rest and aspirin—Marked anorevia, malaise, and pallor had developed—Eight days previously, the left elbow had become extremely painful and tensely swollen, and a few days later the right elbow had become similarly involved—The boy was then brought to

the outpatient department where a diagnosis of acute rheumatic polyarthettis was made and hospitalization was advised

The patient was a normal full term spontaneous dulivery Birth weight was 8 pounds 4 ounces He was formula fed and received vitamins in adequate amounts. He was followed in the Pediatric Outpatient Clinie, and his early growth and development were considered normal. There were occasional respiratory infections and one short attack of diarrhea. In 1945 and again in 1946 he was seen because of fover and joint pain. These attacks were relatively mild and were considered to be rheumatic in spite of the child's age negative x rays, normal sedimentation rate and electrocardiogram. At the age of three, he weighed 20 pounds and at the age of four 35 pounds.

The patient is an only child. The father is living and well and is also a single offspring. The mother is one of 4 fiblings all living and well positive for the sickling trait, but she is not anemic. All 4 grandparents are living and well The mater nal grandmother's sizer died several years ago from sovere anemia, type unknown to the family This woman's daughter aged twenty-seven, is living suffers from anemia, but is said to be in fairly good

health at present.

The patient was a thin undernourished 5-year old Negro boy, appearing acutely and chronically ill. He was pale listless febrile but oriented and cooperative. His intelligence seemed above average He complained of severe pain in both olbows and particularly the right. His temperature was 101 F pulse 90 and respirations 23

The cranium was not unusual The facies was typical of a full blooded Negro but not otherwise remarkable. The cyes were normal without visible interus of the selorac. The cars were not inflamed. The nose was congested and the pharynx was diffusely inflamed. The totalis were surgically absent. The mucous membranes appeared generally pale. The chest showed scattered bronchitic rales throughout both lung fields.

The heart appeared slightly enlarged to the left, and there was a short soft systolic murmur maximal at the mitral area but heard also in the sortic and pulmonary areas. The rhythm was regular The abdomen was flat, soft and nontonder There was a small umbilical hernia. The spicen was not palpable and the liver was not enlarged.

The extremities were thin and the legs were not remarkable except for hyporactive tendon reflexes. The right elbow joint was markedly swollen, diffusely inflamed hot, exquisitely tender and extremely painful on both active and passive motion. Flexion and extension were markedly limited both by pain and by soft tissue swelling. The left elbow was similarly involved but to a much lessor degree.

Five urine examinations showed no abnormalities. The results of the blood tests were as follows red blood cells, 2,760 000 6 Gm. (40 per cent) hemoglobin white blood cells 14 400 The differential blood tests showed the following neutrophils 83 per cent lymphocytes 11 per cent, monocytes 2 per cent, cosinophils 2 per cent, basophils 2 per cent,

myelocytes 1 per cent. The stained smear showed anisocytesus polkylocytesis central pallor, and numerous target cells. There were 3 nucleated red cells per 100 white cells. Numerous sickle cells were seen on the dried stanned smear on January 30, February 6 and February 11 1947

Sicking was immodiately present in the wet preparation and was 70-80 per cent complete in twenty four hours. There was no growth on the blood culture. Kahn and Hinton blood tests were negative the patient s blood type was "A International. Blood calcium was 11 mg. per 100 cc. The sedimentation rate was, on January 32 23 mm. in 1 hour on January 31, 18 mm. in 1 hour and on February 7 8 mm in 1 hour The results of the fragility test were Patient hemolysis began at 0.38, complete at 0.28 Control hemolysis began at 0.42 complete at 0.34

The electrocardiogram showed sinus tachycardia

but was otherwise normal.

Y ray showed the lungs having moderate pulmonary congestion the heart was slightly enlarged and the contour suggested some right ventricular enlargement. Boft tissue swelling of the elbows was evident, but there were no radiographic signs of bone or joint involvement. The cranium, pelvis, and hands were all negative for significant bony pathology

The patient was placed on aspirin and calcium gluconate therapy on admission Pentilllin 20 000 units every three hours intramuscularly was also started because of the respiratory infection and because of the possibility of septic joints before labora tory and x ray studies. The day after admission, temperature rose to 103.4 F and the pulse to 120 These gradually fell to normal levels over the next three days and subsequently remained normal

Because of the sovere anemia, transfusions were then begun, and four transfusions of 250 cc. each were given on January 21 and 28 and on February 4 and 6 Following the first transfusion there was a striking change in the patients clinical condition. His appetite which had been almost lacking became voracious.

His involved joints, which had been improving slowly cleared quickly and completely. His cardiac murmur disappeared Pencillin and salicylates were stopped on January 30 and the boy was allowed out of bed. Temperature and pulse rate remained normal and the sedimentation rate improved rapidly. Subsequent clinical course was one of continued improvement until his discharge on February 13, 1947. He has been seen in the Outpatient Clinic twice since discharge. He has gained 4 pounds, feels well and has had no further joint pain. No cardiac murmur can be heard at present.

Comment

The diagnosis of sickle cell anemia is not a difficult one to make provided that this disease is considered at all To be sure, it is not a common disease, even among Negroes. Ogden found the slokling trait present in 6.5 per cent of 1,602 Negroes studied * Various other estimates have ranged from 5 to 10 per cent Of these, only a

small per cent develop anemia But in the south, in northern metropolitan areas, and in other countries where Negroes comprise a large part of the population, one may expect to encounter this disease sufficiently frequently to be on the lookout for it

The first case presented here represents another instance of the very occasional occurrence of this typically race-specific disease in a white person The boy looks white, his parents appear to be white, and as far as can be ascertained, there has been no Negro blood in his family Yet he has sickle cell anemia The fact that it is impossible to exclude, beyond any doubt, the admixture of Negro blood in his (or anyone else's) remote ancestry, a point so often raised in these cases, is of no practical importance. He is clinically white, and this fact emphasizes the importance of including a sickling preparation in the hematologic examination of any case presenting anemia or the physical signs of blood dyscrasia

Although the cases of sickle cell anemia reported as occurring in the white race are very few in number (18 previously), most of these have occurred, as in this instance, in members of the Mediterranean races It must be particularly distinguished therefore from thalassemia which it resembles closely in many particulars so similar are the blood pictures in these 2 diseases (anisocytosis, target cells, the presence of erythroblasts, increased resistance to hypotonic saline, increased icterus index) and the x-ray changes when the disease reaches that stage (early trabeculation of small bones and late "hair-on-end" skull) that a similar causative background is not inconceivable

The second case illustrates how closely sickle cell anemia can simulate acute rheumatic fever with arthritis and carditis Pointing to the frequency of polyarthritis in sickle cell anemia, Brugsch and Gill have made the plea that not every febrile illness with joint symptoms be considered rheumatic fever in spite of the prevalence of this disease 9 To do so is "particularly regrettable since sickle cell anemia, once considered, can easily be demonstrated by a sealed wet preparation of the blood"

Recent recognition of the heart lesion in sickle cell anemia as a distinct cardiopathy peculiar to this disease and sufficient in itself for producing enlargement, murmurs, and even electrocardiographic changes has clarified the situation con-We need no longer assume a frequent coexistence of rheumatic fever in sickle cell The failure of salicylates, the dramatic response to transfusion, the rapid return of the sedimentation rate to normal, the prompt disappearance of the heart murmur, and the early return to activity without relapse, all pointed

away from rheumatic fever in this case, independently of the diagnostic blood findings. In the infrequent situation where the 2 diseases actually do coexist, Walker and Murphy feel that the fibrinolysin reaction is useful in establishing the diagnosis of rheumatic fever in the presence of sickle cell anemia 5 Their case showed positive clot resistance during life, and autopsy revealed clear evidence of both diseases The technic and interpretation of the fibrinolysin reaction have been described by Tillett, Edwards, and Garner 10

Additional methods for confirming the diagnosis of sickle cell anemia have been described and The differential sedimentation rate are of value described by Winsor and Burch can easily be carried out without special equipment 1 It depends on the in vivo deoxygenation and carbon dioxide saturation of red blood cells by blood pressure cuff constriction before venapuncture is carried out

Similarly, if a finger is lightly constricted by a rubber band until deep cyanosis occurs, before the finger is pricked, sickle cells can usually be demonstrated on dried, stained blood films, and easily demonstrated in the usual sealed wet preparation without waiting a period of hours or days for sickling to develop Sickle cell anemia has also been diagnosed by splenic puncture in 2 cases from unrelated Italian families 11 This raises the speculation about what splenic puncture might yield in some of our supposed cases of Mediterranean anemia

Summary

- The two common clinical types of sickle cell anemia in childhood are described
- A case is presented illustrating each of these types
- An additional case of sickle cell anemia. occurring in the white race, is reported
- The relation of sickle cell anemia to rheumatic fever is considered
- The diagnosis of sickle cell anemia is dis-5 cussed

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CLINICOPATHOLOGIC CONFERENCES

FOURTH MEDICAL DIVISION OF BELLEVUE HOSPITAL, NEW YORK CITY

Date November 24, 1947

CONDUCTED BY ABRAHAM W FREIREICH, M.D.

Carcinoma of the Esophagus without Dysphagia

The patient, G. P., a 70-year-old white man, entered Belleviue Hospital for the tiurd time on May 31, 1947, complaining of constipation and weight loss of nine months' duration. The family history was noncontributory Relating to the past history The patients first admission to Belleviue Hospital was in 1940, when evidence of pulmonary employeems and fibrosis was found. In addition, there was found elongation and widening of the ascending aorta Sputum examinations on three occasions were negative for acid-fast bacilli. The patient also had benign prostatic hypertrophy with a residual urine of 350 cc., however, he refused treatment for this problem and was discharged.

On September 24, 1940, the patient was ad mitted for the second time complaining of generalized weakness, weight loss, and loss of appetite of three months' duration. There was a 25-pound weight loss in the two months preceding this ad mission, and he had lost all desire for food. He had also had one episode of diarrhea followed by constipation. There was no nausea vomiting flatulence hematemesis, postprandial discom

fort, or blood in the stools.

At his second admission, the pertinent physical findings were a temperature of 98 6 F, pulse, 88, and blood pressure, 126/80 The patient appeared chronically ill with evidence of recent weight loss There was a bilateral arcus semilis. The pupils reacted normally to light and accommodation Examination of the fundi revealed the arterioles to be slightly narrowed and tortuous and there was slight arteriovenous nicking The traches was in the midline and the thyroid gland was not palpable. The chest was increased in size in the anteroposterior diameter hyperresonant throughout, except at the right base where there was duliness posteriorly There were dimmished breath sounds at the right base with a few moist rales The area of cardiac dull ness was not enlarged There was a normal sinus rhythm with a vontricular rate of 88 The second aortic sound was louder than the second pulmonic. No murmurs were heard. The abdomen was scaphoid in contour with ovidence of considerable weight loss The liver and spleen were not pal pable. The kidneys were palpable but not en larged, and the aorta could be felt through the abdominal wall. No masses could be discerned The rectal examination revealed a diffusely en larged and nontender prostate of normal con sistency. The neurologic examination was within normal limits. There was no lymphadenopathy

The laboratory findings were as follows urnalysis negative on 2 examinations blood count red cells, 3,730,000, hemoglobin, 12 5 Gm., white cells 5,600 with a normal differential, blood Mazzini reaction negative Blood chemistry nonprotein introgen, 30 mg per 100 cc., cholesterol and esters, 173 and 95 mg per 100 cc., cholesterol and esters, 173 and 95 mg per 100 cc., respectively, cephalin flocculation test, negative phosphorus, 3 43 mg per 100 cc., alkaline phosphatase, 3 0 Bodansky units, acid phosphatase, 17 Bodansky units total serum protein, 5 1 Gm percent, albumin, 3.2 Gm. per cent, globulin 19 Gm per cent, interus index, 4

Roentgenogram of the chest revealed the following "Emphysema and pleurodiaphing matic adhesions at the right base. The heart is normal in size and shape with considerable widening of the supracardiac aorts." Roentgenograms of the upper gastrointestinal tract indicated "No organic legions of the stomach or duodenum. There is a large biliary calculus in the

right upper quadrant"

A barium enema was done, but the barium could not be forced beyond the sigmoid. There was considerable dilatation of the rectum and distal sigmoid. This finding was investigated further by sigmoidoscopy The instrument was passed easily to a distance of 12 inches from the anus A normal mucosa was found, and the ease with which the sigmoidoscope was passed suggested a redundant sigmoid The barrum enema was repeated, and there was no intrinsic organic lezion of the colon noted There was marked redundancy of the eigmoid The patient was afebrile throughout his hospital stay and was discharged as unimproved on the forty-second hospital day, to be followed at the outpatient department.

His third and final admission to the hospital was occasioned by the complaints already men troned. In addition he complained of a cough productive of a small amount of whitish sputum and shortness of breath on effort. At the time of this admission he was so weak that he could not

stand on his feet. Other physical findings were the same as those encountered on his second admission with the exception that his urinary retention had become more extreme. An indwelling Foley catheter was placed into the bladder resulting in prompt relief. The patient was so severely ill that repeat studies of the gastrointestinal tract could not be carried out. Roentgenogram of the chest gave the following data "Heart is normal in size with fusiform widening of the supracardiac aorta and chronic productive infiltrations of the major portion of the right lung with some retraction of the mediastinum."

The laboratory findings were as follows urmalysis, specific gravity 1 020 with one plus albumin, occasional granular casts, and 1 to 3 white blood cells per high power field A second specimen revealed a specific gravity of 1 017 with a trace of albumin, numerous bacteria, and 15 to 20 white cells and 1 to 3 red cells per high power field The blood count was red cells, 4,660,000. hemoglobin, 136 Gm, white cells, 15,000, differential count, stab forms 11 per cent, segmented forms 76 per cent, lymphocytes 10 per cent, monocytes 2 per cent, eosmophiles 1 per Blood chemistry revealed the following nonprotein nitrogen, 50 mg per 100 cc, fasting blood sugar, 72 mg per 100 cc, blood Mazzini reaction, negative The blood phosphorus was 268 mg per 100 cc, the alkaline phosphatase and acid phosphatase values were 35 and 11 Bodansky units, respectively

The course of the patient's illness was progressively downhill from the day of admission. On the twelfth hospital day he developed Cheyne-Stokes respirations, a marked drooping of the right eyelid, and a rise in pulse rate ranging from 130 to 150 per minute. There was a sharp change in the previously afebrile course, the temperature rising to 103 F. The patient expired

Discussion

DR ABRAHAM W FREIREICH On reviewing this case, I find great difficulty in attributing to any one disease the cause of this patient's illness and death

The complaints of weight loss and constipation are met with in a number of conditions. There are two which are always associated with weight loss. These are pulmonary tuberculosis and carcinoma, particularly in carcinoma of the gastrointestinal tract.

Pains in the right lower chest and cough, productive of a small amount of sputum, noted on the first admission, should make one suspicious of tuberculosis. However, three sputum examinations were negative for acid-fast bacilli, and x-ray of the chest on the second admission failed to reveal any evidence of tuberculosis.

His first admission, seven years before the terminal episode, contributes the information that he had a benign prostatic hypertrophy with a residual urine of 350 cc but adds little that can be used in determining the nature of the final disease.

On the second admission, eight months before his last entry into the hospital, symptoms relating to the final episode made their appearance. We note that he had lost 25 pounds in the two months preceding admission, that this was ushered in by an episode of diarrhea followed by constipation and that, in addition, there was generalized weakness and anorexia

The episode of diarrhea followed by constipation is certainly significant. This history in an elderly patient should always make one suspicious of a malignant tumor of the lower bowel. However, one cannot exclude the possibility of other conditions of the bowel which might give rise to similar symptoms, such as tuberculosis, syphilis, or diverticulosis.

The physical examination adds very little to the nature of the illness with which we are dealing

Let us turn to the laboratory data again we are met with information of a negative The urine showed a fairly good concentration in one of the casual specimens and nothing else to make us consider renal disease or any lesion in the urinary tract. The blood count was not remarkable. The Mazzini test was negative The nonprotein nitrogen The total cholesterol was within was normal normal limits, and there was only a slight diminution of the ester ratio The negative cephalin flocculation test ruled against hepatocellular damage The blood phosphorus, alkaline and acid phosphatase, albumin-globulin ratio. serum proteins, and the icterus index were all normal

Therefore, in reviewing the results of the laboratory studies, we have obtained very little help in determining a diagnosis

Now, let us see what help the X-ray Department can give us In addition to the findings on the second admission, we find a normal-sized heart with considerable widening of the supracardiac aorta. There is no mention of any calcified plaques, but it is safe to assume in any individual of this age, and with the further evidence of arteriosclerosis obtained in the examination of the fundi, that this widening was due to arteriosclerosis. The negative Mazzini test helps to exclude syphilis as a cause for the widening of the aorta.

The gastrointestinal tract was studied only at each end. The upper study tells us that there was no organic lesions of the stomach and duodenum. Whether the additional information given us that a large biliary calculus was present in the right upper quadrant, is of any significance is questionable. There is no evidence of any disturbed liver function nor is there any obstruction to the normal flow of bile. I think we are justified in stating that this was a solitary calculus located in the fundus of the gullbladder not giving rise to symptoms.

The first study made with the barium enems begins to confirm our suspicion of a malginancy of the lower bowel. We note that the barium could not be forced beyond the signoid. This is significant. However, it is not conclusive. Obstruction to the retrograde introduction of barium can be due to other causes. Extrinsic obstruction, as from bands of adhesions will give rise to similar findings. Volvulus is most common at this location, particularly in older people with marked redundancy of the signoid such as this patient had

Our hopes in having finally discovered the primary disease process in this patient are somewhat shattered by the report of the sigmoidoscopy and of the repeat barrum enema We are told that the instrument was passed easily to a distance of 12 inches from the anus that the mucosa was normal, and that the sigmoid was This latter fact may explain the redundant previously found obstruction on the basis of a volvulus which was temporary in duration. It is quite unlikely however, that this would have occurred without any evidence of pain and without other evidence of acute obstruction such as vomiting and distension and evidence of a mass in the lower abdomen.

That nothing was found in the distal 12 mehes of bowel does not exclude a disease process somewhat more proximal

The second barrum enema revealed no in transic organic lesion of the colon. Thus information is interesting but not conclusive. It is quite possible for a tumor to be present in the colon and not be demonstrable with a barrum enema

The patient was discharged as unimproved and came in for his final admission approximately seven months later He appeared very weak and was unable to stand and he continued to complain of constinution Urinary retention had appeared, but this was relieved by the indwelling catheter He complained also of cough and of dyspnea on effort That the latter symptoms were due not to cardiac failure but rather to pul monary disease is borne out by the absence of any other signs of congestive heart failure and by the positive evidence of productive infiltrations of the major portion of the right lung. The nature of this pulmonary infiltration is not clear Is it metastatic tumor of the lung? Is it primary tumor of the lung? The retraction of the

mediastinum would make one suspicious of the latter. Is it inflammatory, in character? For the first time we see a leukocytosis of 15,000 with a moderate shift to the left.

The laboratory findings on the last admission, except as noted above, are not significant. The appearance of a one plus albumin, occasional granular casts, some white blood cells, and one to three red blood cells is not uncommon in one dying from a chronic wasting disease. Again there is found no anemia. The slight rise of the nonprotein introgen to 50 in the specimen of blood taken, apparently, on his last day of life is of no consequence. The other tests were all within normal limits.

Just a few words at the mode of exitus The sudden development of Cheyne-Stokes respirations with drooping of the right eyelid and the rise in pulse and temperature were probably due to a crebovascular accident, possibly in the medulia or nons

I feel that this patient had a malignancy of the intestinal tract probably in the left side of the colon. Functionally, the colon can be divided nto a right and a left aide. The right side, con sisting of cecum, ascending colon, and hepatic flexure is wider in caliber and the intestinal contents in this region are fluid. A tumor in this area will grow to a rather large size before making itself evident, because of the size of the lumen and the nature of the contents Anemia appears earlier and obstruction and constinution later The left side of the colon, from the splenic flexure to the terminal portion, is narrower in caliber and the contents here have become more solid Because of this, obstruction and constination appear earlier, and a smaller lesion can give rise to the symptomatology

In the absence of a demonstrable tumor in the descending colon, I would suspect the small in testine, merely on the basis of exclusion and the failure to examine this portion of the gastro-intestinal tract, although it is a fact that tumor in this area is rare.

In addition, the autopsy should disclose arteriosclerous of the aorta, metastatic tumor in the lung and cerebrovascular damage, possibly in the region of the medulla and pons.

DR EMANUEL APPELBAUM The outstanding symptoms in this case were marked and progressive weakness, weight loss, anorexia, and constipation. An episode of diarrhes preceded the onset of constipation. The additional symptoms during the last admission were cough, dyspnea on exertion, and urinary retention. Except for the evidence of marked weight loss, the physical examination was not remarkable. There was indeed a paucity of physical signs. The right lung did show some rales and diminished breath

sounds, and there was diffuse enlargement of the prostate However, there were no abdominal masses, enlargement of the liver, lymphadenopathy, or gross blood in the stools Similarly, the laboratory findings were not revealing There was only a slight anemia. The roentgenogram of the chest showed some infiltration in the right lung. Roentgenograms of the stomach, duodenum, and colon were negative, except for the discovery of the presence of a bihary calculus. On one occasion barium could not be forced beyond the sigmoid. The sigmoidoscope, however, was passed with ease, revealing the presence of a redundant colon.

The available evidence points to a carcinoma of the digestive tract—If that is accepted, then the question is, in what organ? To answer this question, it is necessary to see how closely our case fits the pattern of cancer in the various portions of the alimentary canal

Let us begin with the esophagus In esophageal carcinoma, dysphagia is, as a rule, an early symp-Furthermore, the disease is highly malignant with a rapidly downward chinical course Metastasis is frequently present and occurs relatively early in many cases These striking facts militate against the diagnosis of esophageal carcinoma in our case However, it is necessary to point out that, in the early stages of some cases of esophageal carcinoma, before the growth causes marked narrowing of the lumen, the patient may not suffer from any symptoms There is also the fact that a pronounced anemia is uncommon in Even the roentgenogram may this condition fail at times to identify a malignant lesion in the Occasionally, one encounters a patient with esophageal cancer in whom death occurs without giving rise to any symptoms referable to the esophagus Some of you may recall a case of that type which was presented here about two years ago It is, therefore, not entirely safe to exclude the possibility of carcinoma of the esophagus in our case, although the evidence is very much against the diagnosis

The next organ to be considered is the stomach Except for the anorexia, there were no symptoms or signs to suggest gastric carcinoma. However, there is no symptom complex by which this disease can be identified with certainty. As a matter of fact, it is remarkable to what extent the stomach can at times accommodate itself to extensive local involvement without revealing a trace of disorder.

One might ask then, if it is possible to have carcinoma of the stomach with negative x-rays. The answer is yes. At times cancer in the cardia may be difficult to detect roentgenologically. It may be necessary to take films in numerous positions, particularly in the recumbent and in

the supine with the buttocks elevated Often the diagnosis can be suspected when there is a deformity of the stomach air bubble However, cancer of the cardia is, as a rule, accompanied by cardiospasm and disturbances in deglutition

There are other types of gastric carcinoma that may be difficult to detect clinically and roentgenologically When the tumor involves the posterior wall of the stomach without invasion of the anterior wall or the curvatures, no mass is felt, and the roentgenogram is, as a rule, negative Since these tumors grow slowly, the diagnosis may be overlooked for months or even years One has to mention also the rare instances of very small primary gastric carcinoma which metastasize through the blood stream and the lymphatics to the lungs and even the brain These cases frequently lead to the development of carcinomatous lymphangitis in the lungs Weakness and dyspnea are the striking symptoms in these patients When there is metastasis to the brain, a diagnosis of primary brain tumor may be made In the light of these facts it is erroneously possible to interpret the pulmonary findings and perhaps even the terminal neurologic signs in our case as instances of metastasis to the lungs and

There remain two other points in our case which are difficult to reconcile with the diagnosis of carcinoma of the stomach One is the absence of a significant anemia, and the other is the failure to find gross blood in the stools In regard to the first item, it is necessary to point out that most, but not all, cases of gastric cancer are accompanied by marked anemia, which may be either hypochromic or hyperchromic Indeed, the absence of a marked anemia probably indicates that there was no extensive bleeding, which is necessary to produce gross blood in the stools It has been estimated that it takes approximately 70 cc of blood to produce a stool in which the presence of blood may be detected grossly

This brings us to a consideration of the possibility of primary carcinoma of the small intestine These tumors are rare, and their diagnosis is exceedingly difficult Most of these growths are adenocarcinomata of the annular, constricting type, but they may be polypoid, ulcerating, and nonconstricting Occasionally, these tumors are multiple, particularly those of the carcinoid form The onset of symptoms is most insidious, and they may endure from a few weeks to several years In the nonobstructive stage, the symptoms and signs may be vague The most constant symptoms are weakness and weight loss common, but gross blood in the stools is seldom There may be constipation, or diarrhea alternating with constipation Significant abdominal pain with distension and vomiting are

late symptoms and occur when there is marked narrowing and obstruction of the intestinal lumen. Few positive physical findings are noted in the early stages, but later, there is evidence of weight loss and anemia. An abdominal mass cannot usually be felt, except in the advanced stage, or when there is an associated intussusception. In cidentally, it is important to note that it is characteristic of ileal tumors to produce intussusception into the cecum.

In the light of this discussion, our case seems to fit in fairly well with the diagnosis of primary carcinoma of the small intestine, either in the ieunum or the deum It is however, difficult to reconcile the absence of a significant anemia and the failure to note metastasis. In the final analyms, a definite diagnosis of a tumor of the small bowel can be made only roentgenologically or on

exploratory operation

There appears to be little support for a diag nosis of carcinoma of the colon. There were no obvious clinical signs, and sigmoidoscopy and radiography were negative However, the suggestion of some colonic obstruction on one occasion, as well as the redundancy of the sig moid, may be of significance. It is well known that a point of obstruction is visualized poorly by the barium enema in the presence of a redundant colon In such instances, it is best to rely on the double contrast enema. The presence of marked constipation and absence of significant anemia in our case would fit in with a growth on the left side of the colon. It seems necessary, therefore, to in clude the possibility of carcinoma of the colon.

For the sake of completeness, it is also necessary to mention the possible presence of malig nancy in some organ outside of the digestive tract, particularly some form of retroperatoneal tumor However there is no information avail able to support such a concept As regards the prostate, the evidence indicates the presence of a

benign hypertrophy of that organ In regard to the terminal picture it is very difficult to offer a definite opinion particularly since that stage is described inadequately There was probably circulatory failure associated with a terminal bronchopneumonia. It is of interest to note the elevation of blood urea before death, a not uncommon finding on the last day of hie, which is not necessarily indicative of the presence of primary renal disease. The isolated notation of drooping of the right evelid is difficult to evaluate. It may be a partial Horner's syndrome due to neoplastic invasion of the mediastinal lymph nodes, or it may indicate the presence of cerebral metastama.

The available evidence points to the diagnosis of primary carcinoma in the digestive tract. With regard to the organ involved, I favor the small intestine as first choice, colon, second, and stomach, third.

Dr. Max Truber The chief complaints, precoding the patient's present admission, suggested the presence of a gastrointestinal malignancy but none could be demonstrated

Seven years ago, he entered the hospital because of right chest pain and cough, the sputum was negative for acid fast organisms. A benign hypertrophy of the prostate already gave evidence of urinary obstruction

In 1946, he showed evidence of considerable weight loss. The heart rate was a little accelcrated, and there were findings of generalized arteriosclerosis. There were abnormal findings at the right lung base duliness, diminished breath sounds, and rales Since the left kidney was also palpable, we can assume a beginning hydronephrosis due to the enlarged prostate Renal function was good until his final illness when there began to be a slight rise in the blood nonprotein nitrogen, further evidence of some degree of back pressure. At no time did the urmary sediment suggest significant infection except in the last specimen recorded. Liver function was normal the solitary gallstone would mem to be an innocuous finding. There were no clinical manifestations of carcinoma of the pancreas, which is mentioned only because of the normal gastrointestinal x rays in the presence of major symptoms referable to this system.

On the preterminal stay in the hospital, the appearance of right ptosis suggested the possibility of metastatic disease, in this instance to the Since the prostate seemed innocent in this respect, we have remaining the likelihood of a bronchial carcinoma. The final chest x ray reported infiltration throughout most of the right lung with retraction of the mediastinum. The terminal picture was that of infection with fever, leukocytosis, and tachycardia. Six years ago. diminished breathing was noted only in the right lower lobe, the interval, therefore, was unusually long However I would suspect a right bronchus obstruction with retrograde infection and probably lymphangitic pulmonary spread to account for the preceding dyspnea

Pathology

DR. HENRY SPITZ The anatomic diagnosis revealed the following information squamous cell careinoma of the esophagus, secondary car cinoma in lymph nodes (mediastinal, pre-nortic), and lung extensive fibrous pleural and pen cardial adhesions adenomatoid and fibromuscular hyperplasia of prostate hemorrhagic cystitis hydroureter and hydronephrosis on the left side acute and chronic pyelonephritis, and general ized arteriosclerosis

Autopsy revealed considerable cachevia There was no peripheral edema, and the body cavities contained no excess fluid Both pleural cavities and the pericardial sac were almost entirely obliterated by old, dense, fibrous adhesions The heart was enlarged, weighed 450 Gm, and showed hypertrophy of the left ventricle Minute fibrous scars were scattered throughout the myocardium, and the coronary arteries were slightly narrowed but nowhere occluded by the atherosclerotic plaques, some of which were Most of the larger blood vessels. especially the aorta, showed moderate atheroscler-The lungs were congested, and otic changes throughout the parenchyma, minute nodules could be felt rather than seen The bronchi contained mucopurulent exudate and showed considerable congestion of the mucosa spleen, pancreas, and adrenals presented no important gross changes In the gallbladder a cherry-sized, rounded, greenish-black calculus was found The kidneys were of average size, but the left renal pelvis and ureter were slightly dilated and lined with congested mucosa urmary bladder was slightly dilated, and its mucosa was diffusely congested and focally The prostate was enlarged, parhemorrhagic ticularly the median bar, which seemed to obstruct the urethral orifice Internal and external genitalia showed no other important

The main lesion was found in the esophagus, starting at the level of the bifurcation of the trachea, and extending down to the cardia, but not into the stomach There was a fungating, ulcerated tumor encircling the entire lumen It penetrated the esophageal wall in many areas but did not cause any appreciable narrowing of the lumen In places the neoplastic tissue had caused some thickening of the wall and extended into the adjacent areolar tissue of the medias-Several mediastinal lymph nodes and one pre-aortic node at the level of the first lumbar vertebra were considerably enlarged and replaced The lumen of the esophagus by tumor tissue above the tumor was not dilated, and the muscle not appreciably thickened The stomach and the remainder of the intestinal tract showed no important lesions

Microscopic examination of the tumor showed a fairly well-differentiated squamous cell carcinoma that widely and diffusely invaded the wall of the esophagus The surface of the tumor was ulcerated, and there was marked acute and chronic

inflammatory reaction between and around the tumor cell nests In the lungs tumor tissue was found in the lymphatics of the interlobular septa, around blood vessels, and in the pleura In some areas the tumor had extended into the lung parenchyma and completely filled groups of No metastases were found in the liver Sections of the kidneys showed moderate arterial and arteriolar sclerosis and, in addition, there were streaks of acute and chronic inflammatory reaction extending from the pyramids to the cor-The inflammatory cells were mostly plasma cells and lymphocytes with occasional polymorphonuclear leucocytes The cellular infiltrate was found principally in the interstitual tissue The tubules, especially the lower part of the nephrons, showed evidence of cellular degeneration and regeneration

In summary, this was a case of extensive carcinoma of the esophagus with metastases to regional lymph nodes and lymphatics, spread through the lungs. In spite of the size and extent of the tumor, obstructive symptoms failed to appear, probably because of extensive necrosis and ulceration of the neoplastic tissue.

DR ZACHARY SAGAL I happened to know the postmortem findings and, therefore, did not have the opportunity to join you in discussing the case and in missing the precise diagnosis as you all did From the data given in the protocol, the esophagus could not be suspected as the site of the primary lesion. As Dr Appelbaum stated, a carcinoma of the esophagus is easily missed if there is no appreciable encroachment on the lumen, especially on fluoroscopy with a liquid meal. There were no symptoms pointing to the esophagus and no esophagrams were taken. When a carcinoma of the esophagus is suspected, a thick meal must be given

All those who saw the patient on the ward suspected malignant disease. The first report of a barium enema indicated obstruction at the rectosigmoidal juncture. However, a sigmoidoscopy for a distance of 12 inches from the anus was entirely negative. A second barium enema showed no evidence of any organic lesion of the colon. The stool was not examined for occult blood as it should have been

In general, no one need feel badly about failing to locate the malignancy in the esophagus, as there is nothing in the material at hand to point to it, nothing in the history or physical findings, negative laboratory and roentgenologic reports, and even the terminal events are nonrevealing

A CASE OF WOLF WHITE PARKINSON SYNDROME WITH ELECTROCARDIO GRAPHIC CHANGES AND AN ATTACK OF SUPRAVENTRICULAR TACHYCARDIA. CONTROLLED BY OUINIDINE

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I INTIL rather recently the Wolf White-Parkinson syndrome has been considered rather an uncommon finding. I am certain, however that with more detailed and diligent observation on the part of those seeing patients for the fairly common complaint of tachycardia and palpitation, it will be discovered more frequently It is a condition which can be diagnosed definitely only by the findings on the electrocardiogram

In 1930 Wolf White and Parkinson described a series of cases showing an electrocardiographic preture of bundle branch block and a short P R interval 1 Their names have been attached to this syn This condition is considered benign, the only danger being attached to the attacks of tachy cardia which may throw the patient into congestive

It was suggested by Wolferth and Wood and by Holamann and Scherf independently that this condition was due to a short circuiting of the impulse from the sinus node to the ventricular pathway without having it pass through the AV node and bundle 12 It seems that there must be an accessory pathway between the auricles and ventricles causing this short circuit. This accessory pathway corre-

sponds to the one described by Kent.

On occasion one sees a young adult complaining of a sudden seizure of palpitation, otherwise symptomless at times, or at other times associated with restlessness dyspnes chest pain, extreme nervousness There may or may not be a history of previous attacks of palpitation usually the attacks are of much shorter duration at onset. As these attacks recur they are of longer duration, and, whereas originally they may have coased spontaneously the patient now seeks relief from his physician. The physician usually exerts some form of vagal pressure, feeling that the attack is one of paroxysmal auricular tachycardia. The vagal pressure alone, or this plus a sodative, brings these early mild attacks under control. The patient is assured that his con dition is not serious and is dismissed without further For this reason there is the possibility that some of these patients with unexplained tachycardia may have had the Wolf White-Parkinson syndrome, undiscovered because no electrocardiogram was

The history and findings of the patient reported here falls fairly well into this general pattern.

Case Report

B B a young pharmacist, aged 30, came to me in December 1941 with a complaint of tachycardia, causing restlessness dyspica, and vague precordial distress. The physical examination revealed a healthy man rather pale and restless Blood pres-sure was 130/80 heart rate was 130 regular Vagal sure was 130/80 heart rate was 130 regular Vagal pressure was exerted, and the pulse slowed down to a rate of 96. He was given I grain of phenobarbital

and sent to bed The next day he felt better and the pulse rate had slowed down to 90 His general

appearance was better

Because of the history of frequent sere throats during his early youth and the occurrence of these attacks at irregular intervals from the age of seventeen onward, it was decided to study him further The intervals between these attacks varied any where from five to eight months. They were not induced by any definite emotional or physical strain or pattern Slight exertion such as bending over to tie a shoe lace would be sufficient to induce an attack. They occurred with sudden onset and caused the patient to feel duxy apprehensive dyspheic and discomfort in his chest. The earlier attacks were of short duration and ceased spontaneously went on the attacks lasted longer and required active measures, such as administration of guinidine and sedatives to bring them under control.

In the first attack, seen by me in December 1941, the tachycardla was brought under control by vagal pressure and a sedative An electrocardiogram done the next day showed a very short P R, a prolonged QRS complex and what first had appeared to be Ts in leads 1 2, and 3, depressed S-T in leads 1 and 2 and an elevated S-T in lead 4. Caroful physical examination revealed a soft blowing systolic murmer at the apex which was partially transmitted to the

axilla.

Fluoroscopy showed some straightening of the left border of the heart. Because of the frequent sore throats and these physical findings the ques-tion then arose as to whether we were dealing with an old rheumatic heart as well as a Wolf White-Parkinson syndrome

The patient went along fairly well until December 1943 having had 2 attacks of tachycardia of short

duration since last seen in December 1941

In December 1943, the attack was rather severe causing him much distress. The findings were as The findings were as before with no definite evidence of congestive failure Electrocardiogram could not be done during the acute attack, but the heart rate was about 180 and regular. This attack did not respond to vagal pressure and sedation, and the patient was given 15 grains of quinidine sulfate in three divided doses and sent to bed. The following day the attack of tachycardia had subsided and an electrocardiograph showed the same pattern as the one done in Decem ber 1041

About this time the patient was called up for military service. He told the examining physicians that he was suffering from some form of cardiac condition and that he had a murmer The examining physi clans disbelieved him and told him that the murmer was not heard at this time. He brought his tracings to them and was then deferred because of the find-

On January 10 1947 having had only 2 attacks of tachycardia since 1943, both of which he controlled himself by taking quinidine sulfate he jumped off a counter something which is a daily occurrence and developed a very rapid tachycardia. This time he had more precordial distress then ever before, in-

He felt very giddy and nausecluding actual pain He was markedly dypneic and complained of a feeling of impending death. He did not consult me immediately but again tried to stop the attack himself by taking 3 grains of quinidine sulfate and 1/4 grain of phenobarbital every three hours for three-This, however, was of no avail, and he condoses sulted me the next day with his complaints even more exaggerated

This examination showed blood pressure 140/80, the heart sounds were very rapid, and it was impossible to count the rate No murmer was heard, lungs were clear, and no abdominal organs or masses were palpable Pressure on the vagus and carotid sinus did not slow the rate An electrocardiogram at this time showed a supraventricular tachycardia with a rate of about 210 No P waves were seen and the tracing had the appearance of a nodal tachy-The T waves in leads 1 and 2 became upright, and the S-T's were neither elevated nor depressed Although no rales were heard, the patient acted as if he were in congestive failure placed on quinidine sulfate, 6 grains, and phenobarbital, 1/2 grain every three hours After three doses, making a total of 27 grains of quinidine (including the three doses of 3 grains each, taken before), the attack subsided, and the electrocardiogram, done on January 11, revealed a rate of 90 with a reversal to a short P-R interval and prolonged QRS complex The T-4 in this tracing became diphasic, and the question of myocardial damage again arose pressure at this time was 110/80, and the patient still complained of marked nervousness and apprehension

Forty-eight hours after the last dose of quinidine, the patient complained of vague pains in both infraclavicular areas and the arms and legs Physical examination at this time revealed a healthy looking man with a pulse rate of 90, and regular sinus rhythm blood pressure of 118/80 The systolic murmer at the apex was heard again, and fluoroscopy showed a tendency toward straightening of the left cardiac The electrocardiogram performed at this time showed a perfectly normal tracing with a P-R interval of 0 14 second and QRS complex of 0 07 second The T's of leads 1, 2, and 4 were upright, and the T in lead 3 was isolectric, as were the S-T segments These same findings were present one week later

Summary

This case is presented because of a syndrome which, supposedly-rare, may be found to be not so uncommon if every case of tachy cardia of unknown cause were to be investigated fully As in this case. the lesion would never have been discovered if an electrocardiogram had not been done, even though the patient's symptoms had completely subsided In fact, he had been accepted by the Army, even after calling the attention of the examining physicians to a "heart condition"

Another reason for the presentation is the interesting group of electrocardiographic findings, extending over a period of over five years This last attack of tachycardia was due to a nodal tachycardia with a return to the typical Wolf-White-Parkinson findings after 27 grains of quinidine This is particularly interesting in the light of the 14 cases reported by Stein, where quinidine sulfate was thought to have depressed the abnormal pathway in 1 or possibly 2 of the cases Forty-eight hours after the last dose of quinidine sulfate, the electrocardiographic pattern became completely normal

It is considered that quinidine has a greater affinity for the bundle of Kent than for the AV bundle and is, therefore, supposed to prevent this pathway from functioning in patients with a short P-R interval and a prolonged QRS complex This will allow a normal course for the impulse through the AV node and bundle and, thus, re-establish the normal electrocardiographic pattern, as occurred in this patient forty-eight hours after the last dose of

The prognosis in patients with this symptom complex is, in general, encouraging It is reported that life expectancy is unaffected, their general usefulness as to employment and family life is unimpaired The only danger lies in the fact that if an attack of tachycardia goes unchecked long enough, there is a possibility of decompensation occurring The treatment is expectant, and active drug therapy should be reserved only for the periods of tachycardia

2021 GRAND CONCOURSE

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ALCOHOL BANISHES CANCER IN MICE—BUT MICE DIE

Cancers in mice, of the type known as lymphosarcoma, have stopped growing and begun to disintegrate after injections with small amounts of 95 per cent alcohol, in experiments reported by Dr Allan D Bass and Miss Marion L H Freeman of the Syracuse University College of Medicine

The effect was discovered almost accidentally The two researchers were injecting various drugs, dissolved in alcohol, into mice with malignant tumors

They found that destruction of the growths

was practically as great when alcohol alone was used

The typical dose was a few drops (one fiftieth of a cubic centimeter) of the 95 per cent alcohol injected directly into the abdominal cavity Weaker solutions, such as 19 per cent alcohol, had no noticeable effect

There is just one drawback, so far as possible applicability in human medicine is concerned—a high percentage of the treated mice died.—Science News Letter, February 14, 1948

ELECTIVE TRACHEOTOMY FOLLOWING THYROIDECTOMY

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(From the Department of Surgery St Peter & Hospital)

SURGEONS who operate on many thyroid patients are frequently confronted with the problem of porforming a trachectomy. An indication for trachectomy which is never open to dispute is postoperative tracheal obstruction secondary to hemorrhage Emergency trachectomy in these cases imporative for the preservation of life Elective trachectomy following thyroidectomy however presents a different problem. The question as to when this procedure is indicated may be open to dispute

An elective tracheotomy is advocated in these patients with large colloid golters producing tracheal compression and/or marked tracheal deviation. This is especially true when there is substernal extension of the gland. In the case presented here a satisfactory outcome would have been impossible without an elective tracheotomy.

Case Report

Care 1 The patient M B 56 years of age, was seen in May 1947 He presented the history of a swelling in the neck of ten years duration During the past six months this had increased in size and more recently, over a period of soveral weeks he had developed hoarseness and dyspnea on evertion cause of the hoarsoness and dyspnea, he was re-ferred for surgical treatment. Physical examination at that time revealed an obese man weighing 250 pounds His blood pressure was 190/100 pulse 100 BMR plus 16 The agnificant findings were referrable to the thyroid gland The gland was en larged to twelve times normal size Preoperative x ray study revealed tracheal deviation to the left and a substernal extension of the thyroid into the mediastinum. The patient talked with difficulty and displayed hoarsoness which was his chief complaint. The patient was prepared for operation and subjected to a total thyroidectomy and elective tracheotomy on May 21 1947 He had an uneventful The tracheotomy tube was removed on the second postoperative day and the patient was discharged from the hospital one week after his oper

As demonstrated by this patient, the large thyroid gland displaced the traches. Displacement of this type is conducive to diminution in the exchange capacity of the trachesl alrway. This insufficiency may precipitate anoms. This increases a proviously existing anoxic state which is characteristic of patients with hyperthyroidism. Anoxia is further increased if a nucous plug occludes a major or minor bronchus. Tracheotomy establishes an artificial air way which eliminates the fear of inclipient anoxia.

Often, large goiters insidously compress the recurrent laryngeal nerve. Following the removal of the offending pathology edoma occurs about the site of compression This edoma may result in transutory paralysis of one or both vocal cords paralysis disappears when the edoma subndes In this instance a tracheotomy is indicated until the edema has subsided

In large substernal golters an excessive accumulation of serosanguineous fluid occurs. Failure to drain the operative sites adequately can compress the traches and produce obstruction. Elective trachestomy is a prophy laxis against this complication. The important indication for elective tracheotomy, therefore is trached compression or deviation secondary to large adenomatous golters. This is especially true in these with substernal extensions.

Technic

At the time of thyroidectomy tracheotomy is a simple procedure. The traches is cleaned of thy roid tissue and the cartillagenous rings are clearly visible. The site of election is usually below the second cartilagenous ring, because high tracheotomy may produce laryngeal edema which may result in a stenosis. High tracheotomy is more apt to cause perichondritis for the same reason. Moreover high tracheotomy results in difficult decannulation. For those reasons the fourth cartilagenous ring is the preferable-level.

A vertical incision is made in the center of the fourth cartilagnous ring with a number 15 bladed scalpel. This is usually sufficient. However on occasion a small segment of cartilage has been removed in order to facilitate the entrance of the tracheotomy tube. With the stylette in sutu the tracheotomy tube is inserted into the trachea. The membraneous portion of the trachea relaxes sufficiently to enable the cartilagnous ring to spread

A plain half inch gauze pack is then placed on removed, and the tracheotomy tube. The stylette is removed, and the tracheotomy is allowed to function on the operating table. Anesthesia is generally discontinued at this stage. Since patients with substemal golter are usually given intratracheal anesthesia tracheotomy necessitates the removal of the endotracheal tube.

Complications

The performance of a tracheotomy is not free from hazards Decision not to do a tracheotomy often has been influenced by the fear of complications These complications may occur as follows

Infection.—Thacheal secretions emanating from the trachectomy tube carry organisms into the oper ative site. This may produce a wound infection When silk is used for ligatures, infection is a serious complication. Sepsis is diminished if the dressings are changed overy half hour during the first twenty four hours. Infection can travel substernally and produce a mediastinitis. As a prophylaxis against this, a generous gauze pack is employed to block off the mediastinium. Penicillin is given parenterally during the period in which the trachectomy tube is nistu. In the case reported the patient developed

thick sputum which threatened to block off the This was controlled by penitracheotomy orifice cillin inhalation as a supplement to the intramuscular dosage Twenty thousand units of penicillin are dissolved in 1 cc of isotonic sodium chloride and given five times daily

Emphysema -- Air escaping about the tracheotomy tube may result in emphysema accumulates beneath the skin, subcutaneous em-Mediastinal emphysema dephysema results velops when air dissects under the deep cervical fascia Inspiration produces a normal negative pressure which will increase the spreading power of the If the mediastinal emphysema continues, it may reach the pleural cavity causing a pneumo-The best preventive measure against the development of emphysema is packing. The wound should be packed widely open

Pulmonary Infection — The least probable complication is the development of pneumonia or edema Constant attention to the tracheotomy tube with frequent aspriations employing an adequate suction apparatus will prevent the aspiration of mucus which could stimulate an infection or produce an atelec-If the need arises, penicillin can be instilled into the respiratory tree and the tracheotomy tube

Removal of the Tube

The trachea is a resilient organ and readily returns For this reason a to its proper anatomic location tracheotomy tube is employed for one or two days, three days is the longest time The presence of complications, however, may necessitate leaving the tube in place longer than usual Prior to removing a tracheotomy tube, an x-ray of the chest should be This will demonstrate any fluid accumulation in the substernal space which may be the source of future tracheal compression In the event that the fluid may be old blood, no damage is anticipated if the blood is clotted A large blood clot may be identified by placing a stethoscope over the area A friction rub similar to a pericardial friction rub will be heard The presence of this sound indicates that the tube may be removed, since the blood is If serosanguineous fluid is present, it must be aspirated before removing the tracheotomy tube

The procedure employed prior to the removal of the tube is to defunctionalize the tracheotomy This is simply inserting the stylette into the tracheotomy tube so that it is functionless. If the patient can tolerate this occlusion for twelve hours, it is safe to remove the tracheotomy tube tube should be removed only when the possibility of any complication has been eliminated

Conclusions

- The problem of elective tracheotomy following thyroidectomy is discussed
- The facility of performing this procedure at the time of thyroidectomy is emphasized
- Complications following tracheotomy with the measures employed to prevent them are discussed
- 4 Indications for the removal of the tracheotomy tube are presented

DR BARLOW HONORED FOR TAKING ROLE OF "GUINEA PIG"

Dr Claude H Barlow, whose home is in Trumansburg, New York, has been awarded the Medal of Ment by President Truman for his sacrifice of his own health in advancing the study of bilharziasis. a parasitic disease affecting the bladder

In 1929, Dr Barlow went to Egypt at the request of the Rockefeller Foundation to do research on the disease, learning of the snails which are hosts to the During World War II, Ameri-Bilharzia parasites can soldiers were returning home with the disease, and the United States Public Health Service proposed research to find out whether any American snails might serve the parasite Dr Barlow suggested that an Egyptian sufferer go to America to assist in the studies but was told this was impos-

He decided to provide an infected American-himself-for the lengthy laboratory investigation

Dr Barlow's work, bringing out new facts about the control of bilharziasis, limited the spread and probably prevented the extension of the disease in many areas, according to an official of the Public In 1945, Dr Barlow, his formerly Health Service robust health shattered, returned to work in Egypt, where he is now an expert in the Ministry of Public Health

Ambassador S Pinkney Tuck, presenting the Presidential citation to Dr Barlow in February, said that his act of heroism was an important contri-

bution to America's war effort

ADDITIONAL ANNUAL REPORTS

MEDICAL SOCIETY OF THE STATE OF NEW YORK

1947-1948

Report of the Malpractice Insurance and Defense Board

The Malpractice Insurance and Defense Board consists of

Thomas M. D. Angelo M. D. Chairman
Jackson Heights
Charles Gordon Heyd M. D., I ree-Chairman
New York City
Lee F. Schiff M. D. Plattaburg

John F Kelles M D Utter Christopher Wood M D White Plans Walter P Anderton M D., exofficio

James R. Reuling, M D, ex officio Bayaido William F Martin ox officio New York City Harry F Wauvig, ex officio Secretary New York City

The following annual report is submitted

Abnormal and Difficult Position of Fire and Casualty Insurance Companies.—During the peat year, the Malpractice Insurance and Defense Board has been faced with problems which in part, are the product of the vast social and economic evolution that has taken place in recent years. Of special importance have been the unusual difficulties which have troubled the entire insurance industry in so far as they affect our malpractice insurance problems and the solutions we must find for them.

Mr Alfred M Best, the leading insurance analyst of the country has described the innusual situation as a "three-way squeeze of insurance finances. Through depreciation in the market value of securities, surplices were reduced at a time when the companies were obliged to draw on them to meet the highest loss costs in the history of the business. At the same time, the companies were called upon to finance out of their surplices were called upon the model of the public. To meet this three-way pressure on their facilities, the companies were obliged among other things to apply for increases in rates which were approved by the various insurance departments and to limit the amount of new business accepted in the matter of high less costs and the need for in creased reserves our malpractice insurance followed the general pattern of other casualty lines.

2. Two lacreases in the Base Rate of the Group.

Plan in 1947—For some years the operation of our malpractice insurance and defense plan has resulted in slowly rising deficits. This fact was known to the Board but it was hoped by everyone concerned, including the 10 richbire that this was a tem porary situation and that the tide of losses would eventually turn downward as it had in times past, and that our rates would then catch up with our losses costs. But that did not happen. Instead the cost of current losses continued to rise and in addition losses against previous years matured at costs far in excess of the reserves established for them.

In most forms of insurance the companies know, at the end of the year the number and probable cost of the losses incurred during that year. In malpractice insurance however, the long delay in fling claims and the still longer delay in disposing of them makes it impossible to determine with any degree of accuracy the lose costs of any one year until many years later during which time substantial recrees must be maintained for the protection of the policyholders. For example, in March of this year, a suit was filed against an insured member of the Society because of a treatment given by him seventeen years ago in 1931 and this is by no means an isolated case. Although the statute of limitation in this State is only two years, these delays are possible because the statute may not begin to run until the date of the last treatment given and in the case of a minor until the patient has reached the ago of twenty-two

Early last year an increase of \$4 in our base rate was approved. At that time it was believed that this would be enough to meet the increased costs referred to above but by the end of June, when the figures for the first is months were completed, it was found that our current loss costs for paid and outstanding losses alono had exceeded the total carned premium for that pencel leaving nothing available for reserves necessary for suits which will be filed at sometimen in the future, or for operating expenses. The Yorkshire informed is that, because of this latest increase in loss costs it would be necessary for them to withdraw from the business Accordingly, on July 1, they asked to be relieved of the Group Plan as of September 30, giving us three months in which to find a substitute company and make the necessary arrangements to transfer our business to it.

In normal times, three months notice might have been ample but, as we shortly learned it was not enough in these difficult days when the companies are limiting their acceptance of all new business and are refusing even to consider high loss ratio lines. When this was pointed out to the Yorkahire they immediately recended their notice of withdrawal stating that they would take no action which might leave any member of the Society without insurance protection even for a short time. At the asme time they indicated that because of the heavy increase in losses during the first six months of the year it would be impossible for them to continue our in surance without a substantial increase in rate in the motropolitan area, including. Westchester and Nassau counties. They further proposed, as a temporary measure to assist in financing the increase in reserves, that certificates under our master policy be issued for terms of six months instead of the usual twelve-month period. After considerable negotiations it was finally agreed that no change would be

made in the rate for the upstate counties, but that an annual rate of \$46 would be recommended for the metropolitan area, thus providing semi-annual rates for the two sections of the State of \$16 and \$23, respectively This change was recommended to the Council and approved by it on September 11 to become effective on November 1, 1947

Division of the State for Rating Purposes -Heretofore, the Society has not been willing to consider a differential in rates between the two sections of the State, although frequently urged to do so by both the Aetna and the Yorkshire No provisions were made for such a differential in rates when the Group Plan was organized, and it has always been felt that the cost and benefits of malpractice insurance and defense should be shared by all members on the same basis as the cost and other privileges of membership in the Society Insurance, however, differs from other activities of the Society in that it involves an outside interest, namely, the insurance company, and due consideration must be given to its legitimate requirements

In all kinds of insurance, the companies refuse to accept business from high and low loss cost areas at an average rate because they have learned from experience that they cannot hold the business in the low cost area at an average rate which is higher than that at which some other company could write it at a profit Even if they were able to hold most of it, the loss of any measurable part, obviously, would upset the balance between the areas and leave the company committed to the business as a whole at a rate less than the true average In the case of our malpractice insurance, that would inevitably add to our deficit and that is no longer possible In view of the fact that this is a well established underwriting principle, the Board doubts that it will ever be possible again to secure malpractice insurance in New York from any company at a state-wide average rate

The Wrong Way to Attempt to Lower Insurance Costs -Uninformed insurance buyers frequently measure the value of their insurance by what it costs In times of stress and rising insurance costs, they are inclined to shop about in an effort to find a company willing to quote lower rates When the second company finds it necessary to increase its rates or to decline the business, another shopping expedition has to be undertaken method of trying to reduce insurance costs is dangerous and expensive because, eventually, the bargain hunter will find his insurance in the hands of one of those companies whose policies, too often, have little value except as a basis upon which to sue for the protection which they purport to furnish

pensive that anyone can buy This was forcibly illustrated last summer by the case of one of our members in New York City He had been insured in the Group Plan for some time but, finding that he could get what he believed to be equally good protection in another company at a lower rate, he was persuaded to transfer In May of last year, while treating a patient's eye, he inadvertently punctured the tear duct, causing a certain amount of discomfort but no senious injury to the patient About a week later he met the patient on the street and, during their conversation, the latter made some vague threat of suing him The doctor did what he could to discourage the idea and, believing

that nothing further was likely to come of it, he did

not report the matter to his insurance carrier, in fact, it is doubtful if it ever occurred to him to do so

Insurance which does not insure is the most ex-

In August, however, the patient did sue, and the doctor promptly forwarded the summons and complaint to his insurance company for attention. Instead of accepting the claim, the company returned the papers to him and denied liability for the case, claiming that he had violated the policy contract in that he had failed to give the company prompt notice of the claim. The doctor had been given no notice that the patient intended to sue other than the vague threat made during a chance encounter on the street. Furthermore, the total time between the date of treatment and the filing of suit was only three months, during which defense of the suit could not have been prejudiced by the disappearance of witnesses or the loss of records. We can only conclude, therefore, that the company took advantage of this small technicality to avoid the expense of defending the doctor as well as the cost of any judgment which might be obtained by the plaintiff

The legal counsel of the Society telephoned the claim department of the company to protest their actions and to persuade them, if possible, to accept liability. They refused, however, to reconsider their decision, and made it plain that it was the policy of the company to disclaim liability in all such cases. If it is the policy of that company to deny liability for reasons as frivolous as in this case, a doctor might wonder what other technicalities could be found to void his insurance. This member has learned the hard way how expensive cheap insurance can be

5 The Right Way to Lower Insurance Costs — Experienced insurance buyers know that the cost of their protection depends upon their losses, and that the only sound way in which their premiums can be reduced is by decreasing the cost of their losses. This is a cardinal fact which we can no longer overlook or shrug off while hoping for the best. The time has come for the Medical Society of the State of New York to take stock of itself, to appraise the significance of the rising cost of malpractice claims against its members, and to take aggressive action to reverse this trend

It may be that our seeming indifference to this growing threat has been due to the fact that we have been too well protected All of our errors have been defended by able legal counsel and have been paid for by a dependable insurance company which, in the face of rising deficits, has paid out its money for our protection Has this kind of protection been a good thing for the members of the Society and also for the public, or is it possible that it has not been an unmixed blessing for either of them? The Group Plan was originally intended to protect against the madvertent errors which attend even the most careful of human efforts, to prevent unwarranted attacks by fakers and racketeers, and to spread among the many the losses of the worthy but unfortunate few Instead, it appears, in too many instances, to have dulled the edge of judgment, to have assumed too much of the physician's responsibility to his patient, to have shielded the unworthy, and to have fostered the very carelessness it was intended to offset

Organized medicine will be failing in its duty to the community if it sits by supinely and allows any of its members to shirk the fundamental tenets of their profession in the comfortable belief that "the insurance company will pay for it." There is no room for such complacency in this Society. Of course, the company has the liability and draws its checks to settle our claims, but every dollar of loss payments must eventually come out of the pockets of the members themselves. In addition, the Society

pays in the loss of prestige, of public confidence, and in the low competency of some of its members who regard the rising cost of malpractice insurance, not as a reflection upon the good name of our profession but as a mere annoyance or the signal for a shopping tour to find cheaper insurance

Appeals to self-discipline and pride in professional responsibility have falled, and passing resolutions condemning acts which lead to malpractice actions is no longer enough It is now incumbent upon this Society to reactivate its crusade for a sharp reduc tion in malpractice claims in this State, to study the offenses committed by its members and to free it-self from the burden of those guilty of acts for which no excuse in common decency, can be found

Let us rid our Group Plan of these offenders by denying them the protection which shields them from the consequences of their rash acts This is the first step necessary to stop the rising cost of malpractice losses and insurance rates The Board considers this a measure of first importance and recommends that it be authorized to deny further insurance protection to members guilty of acts for which no rea sonable excuso can be found, provided always that such members shall have the right of appeal to the Council if they feel a decision of the Board has been

6. Criticism of the Group Plan and the Mai-practice Insurance and Defense Board.—During the last few years there has grown up in certain sections of the Society a conviction that there is something wrong with our malpractice insurance and defense plan. It has been continuously charged that court the market high. That the Yorkshire. that our rates were too high that the Yorkshire, instead of incurring deficits, as claimed, was, in fact, making profits in some unexplained way that this Board was blased, or not alert to needed improve-ments which could and should be made and that our business was so desirable that other companies would be glad to have it but were prevented from bidding for it because of some obscure and unspenfied rea sons These are only some of the charges which have been leveled at the Group Plan and at the members of the Board Those which have not been made openly have been bandied about as critical gosaip until many members have begun to wonder what the facts are. It is high time, therefore that

swered with finality for the benefit of all concerned For most members, it would be enough to point out that, had there been any truth in these charges, had the Group Plan been anything less than what it purported and was intended to be, that fact would have been discovered and reported long ago by those members appointed by the Society to supervise it. But, in the circumstances, it appears that something

these manuations be brought into the open and an-

more specific is needed

Insurance is not so simple as our critics seem to think, and malpractice because of the inordinate lag in the incidence and maturity of claims is more complicated than most other forms of insurance To understand this business and to be able to formu late intelligent conclusions about it requires con siderable education in the underwriting principles which govern it as well as careful study and analysis of a large amount of statistical data. The members of the Board have acquired a working knowledge of the fundamental requirements of the business and have devoted a great deal of time to study of the actuard aspects of it, as well as to the many other problems which are involved. In addition the Board had acquired information about numerous other insurance companies, their position with respect to financing new lines of insurance, their attitude toward malpractice insurance, and the poli-cies which govern the conduct of their business The Board, therefore, presumes to speak with authority in stating that there is no samblance of fact in any of the critical ideas which have been conjured up regarding our group insurance plan So that there may be no doubt about any of the points raised, the Board presents the following speclfic facts

(a) Throughout the life of the Group Plan we have bought our malpractice insurance on a more favorable has than any other form of insurance and so long as the Group Plan, as constituted remains in existence, we shall continue to do so

(b) Instead of boing too high our rates at all

times during the last twelve years have been too low less in fact, than the actual cost of our protection. Whether our current rates will be adequate

remains to be seen

(c) The underwriting loss which has been sustained on our business is so large and obvious that it cannot be doubted by anyone. It is true that all companies have incomes from reinsurance and port folio investments which are not credited to their underwriting results, but these are not difficult to understand or to estimate In the case of our business these items have not been large enough to reduce measurably the company's underwriting loss There can be no doubt, therefore that the Yorkshire is worse off financially than it would have been had it not undertaken our business.

(d) The idea that other companies are interested in our business and would like to have the Group Plan is, and always has been, a myth It is even less true in these difficult times, as the Board confirmed during its recent contact with many leading companies to whom our business was offered. Never theless, members of the Society sometimes are con fused by insurance agents who state that their companies would like to take over our business and so the facts of the situation should be presented

If the Society were prepared to desolve the Group Plan, to abandon its control over all the elements which govern the quality and cost of our insurance and defense, and to turn over our business to some company to handle on its own terms and at its own rates it would not be difficult to find one willing perhaps eager to have it. That is what is meant when some agent says that his company would be glad to have our business. Such a com-pany would of course be interested only in the money to be made out of it. It would not have to gamble on a thin margin of profit with a chance of incurring a deficit. There would be no check to keep its rates from rising to a level which would preclude any possibility of a deficit and it is not diffi cult to imagine what our rates might be without the controls provided by the Group Plan

It should be emphasized that participation in the Group Plan is optional If any member believes that he can secure malpractice protection better suited to his needs or pocketbook outside the Group

Plan he should feel free to do so

Study as to the Practicability of Forming a New Insurance Company by Members of the Society - The Board has completed and filed with the Council a study as to the practicability of forming an insurance company by the members of the Society to carry their own malpractice insurance The study is factual and presents both sides of the question without bias, and it was forwarded to the Council without recommendations

Obligations of the Members of the Society to the Carrier of the Group Plan.—Last summer the abrupt request of the Yorkshire to be relieved of our business was received with disappointment and a certain amount of resentment by everyone concerned It was felt that, quite aside from the Yorkshire's request, we should transfer our business to another company as soon as a satisfactory substitute could be found Diligent efforts were made to find such a company, but up to the present we have not been able to do so This has been due, in part, to the cramped situation of the companies referred to at the beginning of this report, but there is another reason which we must understand and weigh carefully, namely that, for the last twelve years, our business has been unprofitable We would delude ourselves. If we failed to assess this fact as objectively as any insurance executive does in considering our business What, indeed, have we to offer an insurance company? The facts are that our permissible expense factor has never paid its full share of the expense ratio of the two companies which have carried our business and our closely · controlled rates have at no time fully caught up with the cost of our losses In short, there is nothing about our business to make it attractive to an insurance underwriter This is an unpalatable fact, but one which must be fully comprehended before we can reach an intelligent decision as to the course which we must follow

This delay in finding a substitute carrier for the Group Plan has given us time to readjust our thinking, to focus attention upon our responsibility for our own loss record, to verify and appreciate the reason for the Yorkshire's desire to get out of the malpractice business last summer, and finally, to make a belated appraisal of our obligation to the company which is implicit in our agreement with

them
When the Yorkshire in 1936 agreed to insure us at
the cost of our losses plus 34 per cent for expenses
and profit, we in turn agreed to pay rates which

would cover those losses plus the specified service charges. There was no contract binding the Society or the members to this agreement but, most assuredly, there was a moral obligation which the company relied upon. Had that not been so the company would not have undertaken our business.

Through the years, the company has discharged its obligations to us far beyond the limits of ordinary business requirements, and we cannot fail to measure our obligation to them by the same yardstick. The large loss which they have incurred on our behalf is the real measure of their service to the Society, and we would be sadly lacking if we allowed our appreciation of that fact to be dimmed by what we regarded last summer as a precipitous decision to retire from the business. Entirely aside from that reaction, we are clearly faced with a moral obligation which involves not only a matter of good management, but also a question of our good faith

If it became known in insurance circles that the Yorkshire was obliged to withdraw from the malpractice field because the members of the Medical Society of the State of New York had failed to meet their obligations, we would do irreparable harm to our good name and to our future insurance protection. The prestige of the Society would suffer and henceforth, no reputable insurance company would insure us under conditions which depended upon the good faith of the members to make the business acceptable, and we would pay dearly for that. On the other hand, if we accept responsibility for our own loss costs, if we undertake an energetic campaign to reduce them effectively, and if we make known our decision to pay rates which will carry our current business and wipe out our deficits, our moral responsibility will be established above question, and the Yorkshire, or any other good company, will then be glad to have our Group Plan with all of the safeguards which it imposes

The Board believes that this is the only course which the Society should permit itself to consider and recommends that such a course be approved.

Report of the Council

Constitution and Bylaws

The Council Committee on Constitution and Bylaws has the following membership

James R. Reuling, M D , Chairman Bayside W P Anderton, M D New York City George W Kosmak, M D New York City

There have been submitted during the course of the year requests from the counties of Albany, Erie, Fulton, and Ontario for approval of changes in their bylaws. In all but one instance these were found not to be in conflict with the Constitution and Bylaws of the Medical Society of the State of New

York, and therefore all of the requests were approved with the one exception noted. In this instance the proposed change was not at variance with any provision of the State Constitution. However, on advice of Counsel of the State Society, it was deemed inadvisable to have a "probationary" or "waiting period" for members before being accepted and therefore, on the recommendation of the Committee, the Council disapproved this provision in the bylaws of a component county society

At the last meeting of the House of Delegates of the American Medical Association a change in the bylaws of that Society was adopted to make uni form the beginning of the term of office of all delegates from constituent associations to the American Medical Association In order to conform to the proposed changes in the bylaws of the American Modical Association, it is recommended that an addition be made to the first sentence of Chapter 3 Section 7, of our bylaws "To commence the first day of the January next succeeding each delegate s election." The Section would then read "The delegates to the American Medical Association shall be elected in the calendar year preceding the meeting of the House of Delegates of the American Medical Association to which they are elected and in accordance with the constitution and bylaws of that body for a term of two years to commence the first day of January next succeeding each delegate s election Delegates may be elected to other medical societies or similar bodies as the interest of the Society may require, and credentials shall be issued to all delegates signed by the President and Secre-tary " The Council of the State Medical Society, at its meeting on January 15 1948, recommended that this change be referred to the House of Delegates for its action

PART XII

Questions on Ethics.—The Council Committee on Questions on Ethics has the following member ship

James R. Reuling, M.D. Charman Bayside Charles C. Trombley M.D. Saranac Lake Morris H. Nowton M.D. Lattle Falls

The Council Committee on Questions on Ethics has had submitted to it from various sources five questions during the past year. On only one of these did it seem advisable or necessary to call the committee. In this one case the question was settled by a mail vote and all matters were approved by the Council

At the last meeting of the House of Delegates an addition to the Principles of Professional Conduct was adopted as follows

31(b) Publications for the Laity

Members of this Society who have prepared and written a book, article or any writing per taining to medicine for the laity and intended for publication shall submit the same to the Council Committee on Public Relations and the Public Relations Bureau of the Medical Society of the State of New York for approval prior to any publication then and in that event any proposed advertisement for or announcement of publication thereof shall be likewise submitted to said Council Committee and Bureau for approval prior to any appearance thereof in print. The reviewing committee shall render its opinion without unnecessary delay. This Committee shall be in the main guided by Section 31 of the 'Principles of Professional Conduct,' but shall be empowered to make such concessions as may be practiced and necessary in considering the title of the publication, the description of the content, the responsibility, standing, and reputation of the writer and such other material through which the publisher wishes to arouse reader interest

l ollowing the publication of Section 31(b) Principles of Professional Conduct, as quoted above there were a number of letters sking for clarification and some letters objecting to the intent and purport of the principle as adopted. The Section was presented to the Council and was discussed at length at several meetings. The Council recommends that the House of Delegates resolud this principle. It is the opinion of the Council, concurred in by the council of the Section 31(b) and present written may involve infringement of the constitutional right of free speech. The Committee on Questions on Diblics was requiseted to revise this principle to remove the objections. There is therefore submitted to the House of Delegates by direction of the Council the following recommendations

To rescind Section 31(b) as now standing

2 To insert in its place
Advertisements and Announcements of Publications for the Laity

In the event that there is proposed any public announcement of or advertising in relation to any book or article or writing for the laity such proposed announcement or advertising matter shall be submitted to the Council Committee on Public Relations prior to any public appearance of the announcement or advertising matter. This reviewing committee shall render its opinion without unnecessary delay. It shall be guided mainly by Section 31 of these principles of professional conduct, but shall be empowered to make such concessions as may be practiced and necessary, in considering the description of the title and content of the publication the professional standing and reputation of the author and such other material through which the publisher may wish to arouse interest.

ABSTRACT OF MINUTES OF THE COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

A TITS meeting on February 12, 1948, the Council considered the following matters, taking action as indicated

Secretary's Report

Remission of State Assessments—Remission of State assessments was voted on account of service with the armed forces for 55 members for 1948, 6 for 1947, and one each for 1941 through 1946, also on account of illness for the following members ac-

cording to county

Bronx Lawrence Jacobius, 1947 Erie 1947—T N Alpert, L Franklin Anderson, Raymond G Bell, Bert J Bixby, Emerson Holley, Otto S McKee, George W Schaefer, Bernard F Schreiner, William T Shanahan, Edward H Storck, Thew Wright, and George R Critchlow, 1948 Kings 1948—Max Lederer, Joseph F Morris, Phillip Oginz, Anna M Ralston, Lorne McD Ryan, Norman W Taylor, Irving Tran, and Stephen Szalay, 1947 New York Alex M Gluckstein, Bertram E Marks, 1948 Onondaga Richard K Vosburgh, 1947 Queens Frederick P Tietz, 1947 Westchester Arthur F Heyl, 1948

Meetings —During the past four weeks your Secretary has attended the regular committee meet-There have been three meetings of the Workmen's Compensation Fee Schedule Advisory Committee This Committee's work has almost finished It is presumed that a report will be in Miss Mary Donlon's hands in the near future On January 6, Dr Aranow and I attended a meeting at the Association of the Bar of the City of New York where representatives were also present from several other professions-mining engineers, electrical engineers, civil engineers, accountants, dentists, and the League of Professional and Business Women, among others It was agreed to further the Silverson Plan which has been introduced in the Congress, which would make it possible for partnerships, individuals, and small business people to insure themselves under the Social Security Administration against old age

Another meeting will be held this month
On January 22, Dr Herbert H Bauckus and your
Secretary conferred with Dr Ethan Flagg Butler
and Dr J C Harding of the Veterans Administration, Washington, regarding work of the Veterans
Medical Service Plan of New York, Inc The
Medical Society of the County of Kings kindly invited your Secretary to a dinner in honor of Dr
Koplowitz, past president, at the Columbus Club,
Brooklyn, on Thursday, January 29 The main
speech of the evening was delivered by Dr Louis
H Bauer, president of the Medical Society of the
State of New York, who also presented the Medical
Society of the County of Kings' President's medal
to Dr Koplowitz At a dinner of the Medical
Strollers on Saturday, January 31, your Secretary
took the liberty of speaking for a few minutes about
the importance of fighting the bill to heense chiropractors On February 2 he attended, with Dr
Aranow, Mr Anderson, Mr Walsh, and Mr Miebach, a meeting with executives of the State Charities Aid Association at 105 E 22nd Street, where
methods were discussed regarding combating the
chiropractic bill and other legislation

A questionnaire was sent to county society secretaries regarding the annual meeting of these gentlemen. Their replies will be tabulated and several

constructive suggestions acted upon in preparation for the meeting next year

Communications—Letters and resolutions were received in regard to revision of the Workmen's Compensation Minimum Fee Schedule from the following Dr O J McKendree, retiring secretary of the Medical Society of the County of Oneida, Dr Irving L Ershler, secretary of the Onondaga County Medical Society, enclosing a resolution unanimously adopted by that Society on January 6, 1948, Dr C F Prairie, secretary of the Medical Society of the County of St Lawrence, Dr Philip M Standish, secretary of the Ontario County Medical Society, and Dr Irving Drabkin, secretary of the Medical Society of the County of Nassau

After discussion, it was voted that the secretary acknowledge these various resolutions, call attention to the fact that at the hearing on December 15 the opportunity for criticism was extended until February 1, and that a number of suggested changes have been received and have all been turned over to the Committee for consideration, and that while the Commissioner has not yet ruled on them the Advisory Committee has recommended the adoption of many of the suggested changes received from the county societies, and that the fee schedule will probably be promulgated in the near future

Letter from Dr Charles F McCarty, as secretary of the Coordinating Council of the Medical Societies of the Counties of Bronx, Kings, New York, Queens, and Richmond, under date of January 28, 1948, requesting permission to have the Economics Committee of the Coordinating Council meet at the State Society's offices at 9 PM on the first Tuesday of March, April, May, October, November, and December

After discussion, it was voted that Dr McCarty be informed that the State Society is willing to have the Conference Room used at the times indicated, without guarantee that this privilege can be continued, and that attention be called to the fact that persons using the building evenings must register, also that it will be necessary to have a member of the staff present who will have to be paid overtime. Therefore, it is expected that this expense will be met by the Economics Committee of the Coordinating Council

Letters from Dr Harry Aranow, chairman of the Nominating Committee of the United Medical Service, dated January 30, 1948, stating that the United Medical Service is required to have nominated from the council names of 13 physicians for "directors of the first category"—physician directors The following names were submitted

First Class, to serve until the Annual Meeting of Voting Members in 1949 Harry Aranow, John B D'Albora, Chester O Davison, William B Rawls Second Class, to serve until the Annual Meeting of Voting Members in 1950 Thomas M D'Angelo, M J Fein, David J Kaliski, M DeM Tourat Third Class, to serve until the Annual Meeting of Voting Members in 1951 Milton J Goodfriend, Chas Gordon Heyd, John J Masterson, DeWitt Stetten, Nathan B Van Etten

It was voted that the Council nominate the foregoing doctors as requested by the United Medical Service Nominating Committee

Letter from Dr John A. Toomey president, and Dr Clifford G Gurlee, socretary treasurer of the American Academy of Podiatrics, January 30, 1948, thanking the Society for their assistance in helping to collect data in conduct of their surveys.

Resolution from the Medical Society of Jefferson

County reading

"Wheneas, under existing laws, both State and Federal, it is mandatory that all payments for medical services rendered must be paid direct to those clients (patients) who are receiving assistance in the federal categories namely, old age assistance, aid to the blind and aid to dependent children, instead of to the physician who has rendered such services, such procedure, in many instances, results in nonpayment by the client to

the physician
FURTHERMORE, it has been found on investiga tion, that money which had been sent to the client (patient) for payment of medical services rendered had been diverted to other uses and the physician not paid Such a procedure, as is now in exist-ence, is not conducive to the best medical service as physicians are loath to continue visits to patients who do not or will not pay for services ren-

dered, therefore

Be it resolved by the Medical Society of Jeffer son County, that the present procedure on pay ment of fees be brought to the attention of the State Medical Society, the New York State Welfare Association and the Board of Supervisors, and through these agencies to the attention of the proper authorities in Washington, in order that the present existing methods of payment may be corrected so that the physician may be paid di rectly instead of through an intermediary

After discussion it was voted that this be referred for reply to Dr Christopher Wood chairman of the Subcommittee on Public Medical Care suggosting that it is a federal and not a state regu lation which requires payment direct to the patient, that the State has to comply with this in order to receive reimbursement that this has been referred to the Subcommittee on Public Medical Care for consideration in that it involves questions of general policy that the Society has always stood for noninterposition of a third party between the doctor and the patient, and that this matter should be handled with caution.

Letter from Dr Earl LeRoy Wood secretary of the Medical Society of New Jersey January 27 1948 inviting representatives to the annual meeting of his society

It was roted that the nomination be left to the president.

Letter from Dr Frederick MacCurdy Commissioner of Mental Hygiene of the State of New lork, stating that he had appointed Dr Harold R. Merwath as a member of the Board of Psychlatric Examinors in accordance with the nomination from this Council

Lotter from Dr Charles F McCarty, director of the Medical Society of the County of Kings, recom-mending that Dr Maurice E Connor 1320 Carroll Street, Brooklyn, be made an Affiliate Fellow in the American Medical Association Such nomina tion comes from this body to the American Medical Association

It was voted that this recommendation be made

Letter from Dr A. W Martin Marino president of the Medical Society of the County of Kings

and Academy of Medicine of Brooklyn, February 6 1948, reading

"Messrs Martin & Clearwater 30 Broad Street New York 4, New 1 ork

"Gentlemen

Your letter of January 21 1948, addressed to our Counsel Mr Edmund A Whalen, was considered at a meeting of the Trustees on

Wednesday of this week.

"I do not think that it is necessary to discuss at length the original agreement of 1906 between the State Medical Society and our Society, and the slight modification of the same in 1914. The Trustoes examined into all the records in our possession concerning the said agreement and the operations thereunder for the past forty years. They are confident that our Society has fulfilled all of the terms of the agreement. They desire to call to your attention the all-important fact that at the time the original agreement was entered into, our Somety discontinued the publica tion of the Brooklyn Medical Journal. The Trustees are of the opinion that should the State Society desire to have a mutual termination or modification of the original agreement, then it would be incumbent on the State Society to es-Journal of the Medical Society of the County of Kings and Academy of Medicale of Brooklyn, whereby our Society would have all the advantages which it had originally when it published the Brooklyn Medical Journal

The Trustees feel that it is worthy of note that after the probation period of five years, from 1906 to 1911, the State Society reaffirmed all the terms and provisions of the original agreement.

Letter from Dr Walter W Palmer member of the Board of Governors of the American College of Physicians February 2 1948, requesting that the Society invite the American College of Physicians to hold their annual meeting in New York City in 1949

It was voted to issue the invitation.

Letter from John Hunton, secretary treasurer of the Conference of Presidents and Other Officers of State Medical Associations, February 5 1948, requesting the Society to send representatives to their Fourth Annual Conference in 1948, and pay dues of

Dr Bauer stated that this matter came up a year ago, and the Council replied that in view of the fact that the American Medical Association House of Delegates is now meeting twice a year, plenty of op-portunity is afforded to consider so-called grass roots problems, that we see no particular value in this organization, and that unless they could inform us of some particular reason why we should be a member, we did not care to contribute.

It was roted that a letter be sent to this Conference inviting their attention to our letter of a year ago and stating that we are still of the above opinion, contained therein

Dr Anderton read an excerpt from a letter from Dr George F Lull, secretary of the American Medical Association, dated February 2 1948. It refers to an explanation of the American Medical Association Speakers' Bureau which is being sot up under the Bureau of Health Education of the Ameri ean Medical Association

"We will also be glad to bear from the secretaries

of state and county medical societies the names of available speakers in their jurisdictions so that requests for speakers received at headquarters can be referred to local speakers, either direct or, if preferred, through the secretaries of state and county medical societies

"This experimental service, if successful, can be the nucleus for the nationwide Speakers' Bureau which, in coordination with local speakers' bureau organizations within the structure of the A M A, can render an important service to the public through the medical profession"

Inasmuch as our Public Relations Committee has been working on the idea of a Speakers' Bureau, Dr Anderton felt that this matter should be drawn to the attention of the Council

Treasurer's Report was accepted

Report of Executive Officer

Dr Hannon, chairman, reported

"Through the mandate of the House of Delegates we have had introduced in the Legislature a bill to abolish the Medical Practice Committee of the Workmen's Compensation Board Also a bill to define x-ray as the practice of medicine We have had introduced a bill to amend the Penal Law which would require any person treating the human body to be licensed under the Education Law

The Conference of the County Legislative Committee Chairmen will be held in Albany to act on bills in which the Society is interested on Wednesday, February 25"

Report Accepted

Activities of Committees

Constitution and Bylaws -In the absence of the chairman, Dr Reuling, Dr Anderton reported that the Medical Society of the County of Eric requested approval of a change in their bylaws, establishing a nominating committee

It was voted to approve these changes

Malpractice Insurance and Defense Board.—Dr Anderton reported that he had received from Dr Thomas M D'Angelo, chairman, a copy of a study regarding formation by the Society of an insurance company for malpractice hability

After discussion, it was voted to distribute a copy of this report to each member of the Council, for subsequent discussion

Nursing Education -Dr Frey, chairman, reported that the Coordinating Council on Nursing Problems had met and endorsed the amendment to the Nurse Practice Act, submitted by Senator Mahoney and Assemblyman Strong, authorizing the Education Department to license, without examination, for the practice of registered professional nursing, graduates of accredited schools outof-town, out-of-state, province, or country

This Council endorsed the proposed amendment to the Nurse Practice Act submitted by Senator Hollowell and Assemblyman Stuart, authorizing the

Education Department

(a) To license without examination a graduate of a school of practical nursing accredited in any other state, province, or country, who has completed a course of study in nursing considered by the department to be equivalent to that required in this State at that time and who was licensed in that state by examination, and has met all the requirements as to age, character, citizenship, and preliminary education

(b) To admit to examination a graduate of a school of practical nursing accredited in any other state, province, or country, who has completed a course of study considered by the department to be equivalent to that required in this State at that time, and has met all the requirements as to age, character, citizenship, and preliminary education

It was voted to approve these actions of the Coordinating Council on nursing problems

Office Administration and Policies -Dr Anderton reported for the chairman, Dr Masterson, that the Office Administration and Policies Committee met on Tuesday, February 10, 1948, and considered routine business matters concerning employees, the engagement of new employees, and changes in salary, which will be reported to the Trustees

Also the Committee approved the report, dated February 6, 1948, part of the agenda of this meeting, with the recommendation that it become part of the annual report to the House of Delegates

This recommendation was approved Planning Committee for Medical Policies —Dr. Kenney, chairman, reported that he and Dr Mitchell had attended the meeting of the State Advisory Council of the New York State Joint Hospital Survey and Planning Commission, of which Mr Lonsdale, Welfare Commissioner, is the chairman and Dr John Bourke the managing director, on January 15, 1948 This meeting was under the chairmanship of Assemblyman Lee B Mailler in Albany was presented to that Council the essentials of a coordinated hospital plan for New York State Dr Kenney also spoke at that meeting about Rural County Health Center and Hospital Plans, and his statement was accepted as part of their minutes He thought that the article would be of interest to the members of the Council

Dr Bauer suggested that this be mimeographed

and distributed to the Councilors

Dr Kenney also stated that the question of revising the District Branches was being discussed Dr Kenney reported that he had attended, at the request of Dr Bauer, a meeting on January 23, 1948, of the Fifth Annual Conference on Labor Health Security at the McAlpin Hotel, New York City

Public Health and Education -Dr O W H

Mitchell, chairman, reported as follows

January 15, 1948 In Albany to attend a meeting of the New York State Joint Hospital Survey and Planning Commission

January 16, 1948 In Albany conferred with Dr Harry V Gilson, Deputy Commissioner of Education, New York State Education Department, and representatives of the New York State Association of School Physicians

February 6, 1948 A meeting of the Council Committee on Public Health and Education and the February 6, 1948 Subcommittee on Nutrition was held in Albany Some of the officers of the Medical Society of the State of New York and representatives of the New York State Department of Health were present

February 11, 1948 In New York City a meeting of the Council Committee on Public Health and Education and the Subcommittee on Mental Hygiene was held. Also present were some of the officers of the Medical Society of the State of New

The following report is submitted

"The Committee on Mental Hygiene of the Medical Society of the State of New York wishes to submit the following report and recommendations to the Committee on Public Health and Education

It is apparent that the development of psy chatry and mental hysicae has gone beyond the limited conception envisaged by the State De-partment of Mental Hygene, and a more compre-bensive approach to the problem now exists.

Present facilities for the care of those persons who are psychologically or mentally ill are in-adequate in the State of New York There is great need for psychiatric centers in more cities, to be established in connection with general hespital facilities. There is also need for more in lensive programs of mental hygiene chaic care for those individuals who are ambulatory and who can receive such care to good advantage

We recommend that an Advisory Mental Health Council be established similar to that now functioning with the State Department of Health designated the Mental Health Council and to consist of persons cognizant of the broad field of Such advisory mental health mental hygiene Such advisory mental health council shall not include persons in full-time em ploy in the New \ ofk State Department of Mental Hygiene A council so established should represunt the fields of psychiatry medicine, public health psychiatric nursing psychiatric social

work, and clinical psychology
This Mental Health Council should consist
of the Commissioner of Mental Hygiene and eight members hereinafter called the appointive mem bers to be appointed by the Governor, of whom five at least shall be physicians who are graduates of a medical school approved by the New York State Department of Education and Icensed to practice medicine in the State of New York.

Representing the field of psychiatry three of the members should be physicians who are recognized psychiatrists, at least one a prominent educator in the fields of psychiatry and mental hygiene one physician should represent the field of public health and be qualified in this field and one physician should be actively engaged in the practice of medicine. One member should be a nurse registered in the State of New York and qualified in the field of psychiatric nursing One member should be a psychiatric social worker with clinical experience in this field and one mem ber should be a qualified psychologist certified by the Department of Montal Hygiene in the State of New York. Each of these members shall have had at least five years experience in their respective fields

The Committee on Mental Hygiene of the Medical Society of the State of New York urgently requests that the Council pass a resolution to bring these needs and suggestions to the attention of the Governor of the State of New York so that immediate steps be taken to cope with this most

important public health problem

It was roted that the report be accepted subject to approval by the Council Committee on Public Health and Education

Pebruary 11, 1948 In New York City your chairman attended a meeting of the Subcommittee on Cults with members of the Commission.

Subcommittee on Geristrics.-Dr Stephen R. succommittee on Geriatrics.—Dr Stephen R Monteth Chairman, reports that a conference has been held with Dr Henry S Simms, assistant pro-fessor of biochemistry, College of Physicians and Surgeons Columbia University concerning the organization of genatric research in the State Reports concorning other conferences and communica

tions will be presented at the March meeting of the

Postgraduate Education.—Postgraduate instruction is being presented in the following countries Chnton, Jefferson Nassau, Ontario Richmond, St. Lawrence Schenectady Suffolk, and Sullivan

A symposium on rhoumatic fover, consisting of three speakers has been arranged for the Oneida County Medical Society on April 13 1948 in Utica

A sories of postgraduate lectures on gynecology in April and May has been arranged for the bullivan County Medical Society

A Teaching Day on kidney diseases, on February 19 1048, was arranged for the staff of the Mather Memorial Hospital in Port Jefferson New York

Copies of the 1946-1947 Course Outline Book have been mailed to the newly elected officers, chairmen of Committees on Public Health Postgraduate Lducation Program, and Delegates of the County Medical Societies

Public Relations.-- A newspaper release was sent to daily papers in New York State based upon the editorial in the January 15 issue of the New York STATE JOURNAL OF MEDICIND entitled "The Voluntary Hospital

Mr Frederick W Miebach was employed January 26 on the staff of the Public Relations Bureau, replacing Mr Edgar Lum Cook. Mr Miebach comes to us with a long experience as a newspaper reporter editor and public relations man for various organiza tions

Mr Anderson Mr Wash, and Mr Miebach will attend the meeting of the subcommittee on Cult

Practices, February 11 1948
On February 5 the Public Relations Bureau mailed to State officers, county society presidents and logislative chairmen of the Woman's Auxiliary a specially prepared bulletin containing "Specific Suggestions for County Legislative Chairmen. These will be followed in a few days by two other bulletins explaining how the Woman's Auxiliary can assist the Society in its public relations work by informing the public as to chiropractic legislation and other matters

The Woman's Auxiliary has done a splendid job in supplying the Public Relations Bureau with new names for our direct mail list of important persons throughout the State Approximately 6,000 stencils have been added to this list making a total of approximately 31 000 names of influential people These stoneds are ready for matant use in presenting our ado of any controversial assue to the public

The following postgraduate sessions under the auspices of the Committee on Public Health and Education were covered by releases to the press Clinton Jefferson Nassau Oneida, Richmond St Lawrence, Schenectady Suffolk, and Geneva

Academy of Medicine

Publication.—Dr Kosmak, chairman reported that the Publication Committee held its regular monthly meeting on February 10 1948, and considered a number of routine matters. It also discussed the annual report to the House of Delegates and spent considerable time discussing Directory matters. The next issue of the Directory is in the process of being published but will probably appear late in December of this year or possibly in January It was voted to recommend to the Council that the next Directory be dated 1949

He emphasized that the Directory has become an expensive item in the finances of the Society and that the costs of printing have become about double the costs of the 1941-1942 book Formerly the

"On January 28, the doctor acknowledged receipt of our letters of January 15 and 23, and asked again for cooperation, hoping that it would be possible to arrange a conference in Rochester with Mr Martin, Mr Cahal, his attorneys, and Dr Kaliski We again replied on January 29 that the matter would be brought to the attention of the Council on February 12, and would advise him of the results"

After discussion, it was voted that the Counsel write to the doctor stating that from the information presented, the Council has determined this is not a suitable case in which the State Society should intervene

Special Committee on Editing House of Delegates

Resolutions —Dr Andresen reported

"Dr Floyd S Winslow as chairman of the New York State delegation to the House of Delegates of the American Medical Association presented to the Council at its meeting June 19, 1947, a recommendation that the Council establish a mechanism for assisting reference committees in editing resolutions in the House of Delegates of the Medical Society of the State of New York before they are reported back to the House The Council appointed a committee to consist of the speaker, the vicespeaker, and secretary, to work out a recommenda-tion and submit it to the Council in time for it to be incorporated in the Annual Report

"This Committee reports as follows

'The Publication Committee has offered to make available for this purpose two members of the editorial staff of the JOURNAL Miss Alvina Rich Lewis and Miss Anne Gibson Arrangements are to be made to give them desks easily accessible to the rooms in which the reference committees will sit It is believed that they can bring to this work the same editorial skill they exercise in their Journal work without altering the substance or meaning of resolutions Since there are comparatively few such resolutions, their services could also be made available (subject to the priority of editing resolutions) for the purpose of assisting chairmen of reference committees with their reports The entire task of reports would perhaps be too great for a staff of two persons It is suggested that a limited service of advice and suggestions be rendered at the 1948 meeting on reports other than resolutions, for the purpose of experimenting, to learn how much farther it will be feasible to extend such service in the future'"

It was voted that the report be accepted

Red Cross Blood Banks -Dr Todd reported that Dr Bauer had requested him to attend, as State Society representative, a recent meeting between Red Cross representatives and the Comitia Minora of the Medical Society of the County of New York This had to do with the subject of blood banks in New York City and elsewhere

NO NORM OF PHYSICAL FITNESS, SAYS DR. RUSK

The term "physically fit" means nothing in itself, declares Dr Howard A Rusk, rehabilitation specialist There is no yardstick to define physical fitness, he says, hence the real question is, "Physically fit for what?"

Almost a million servicemen, inducted as physically fit, had to be discharged for disability, 90 per cent of it due to illness, he says On the other hand, he points out, thousands of 4-F's proved highly useful in the war effort in specially selected tasks emphasize his point that there must be an individual

appraisal of each person's health and what it fits him to do, Dr Rusk reports a survey of 2,000 executives in a large, prosperous corporation. The study disclosed that "62 per cent had major diseases potentially serious to health" and all the rest needed treatment for minor ailments

Physical fitness has long been associated with so-al success, he concludes "Times have changed cial success, he concludes but the popular concept has not What we need is a new yardstick."-Medical Economics, January,

DR MAGNUSON'S VA STATEMENT CAUSES STIR

Shortly after Dr Paul B Magnuson took office as chief medical director of the Veterans Administration in Washington, he issued a statement to the press in which he said he was going "to clean out the skunks and chiselers" who overcharge GI's for medical service The Chicago Tribune's lengthy story about Magnuson's statement was headlined "Oust Skunks, Savs New VA Medical Head"

Within an hour after Dr Magnuson made his announcement that he would submit to the American Medical Association a list of private physicians suspected of overcharging or of unfair practices in treating war veterans, Dr George F Lull, AMA. secretary, issued a statement, which was carried by

the press, to the effect that if such a list is submitted

it will be turned over to state medical societies.

The American Medical Association is a federation of component state societies, Dr Lull said, and it is up to these medical societies to take whatever action they wish The machinery for disciplining members exists within the state societies and not within the AMA.

Meanwhile, the State Council of the Illinois State Medical Society adopted a resolution protesting against Magnuson's language The council said his reference to "skunks and chiselers is intemperate and gives an unwarranted false impression."—Secretary's Leller, A.M A, January 26, 1948

DEPARTMENT OF MEDICAL CARE INSURANCE

CONDUCTED BY GEORGE P FARRELL, Director

New York State First to Exceed 1,000,000 Members in Voluntary Nonprofit Medical Care Plans

MEMBERSHIP in the six voluntary nonprofit medical care plans, underwritten and spon sored by local county medical societies and approved by the Medical Society of the State of New York, has shown remarkable growth with an increase of 425 000 members for 1947 giving a total membership of 1 023,615 on December 31, 1947 The corresponding gain in 1946 was only 329 000 members.

Operating under the sponsorship and control of the medical profession the voluntary nonprofit medical care plans in New York State have shown continuous and sound growth, with the largest membership of any state offering similar plans. The medical profession has made marked ad vancoment in the art and science of medicine, and

it is becoming more evident, as indicated by the growth in the voluntary nonprofit plans that the same art and skill is being applied effectively in the field of medical economic

There were 111 592 claims during the year and benefits incurred for the subscribers and members of their families amounted to \$3,831,555, an 83 per cent increase compared to \$2,009 869 in 1946. The total surplus of the medical care plans amounted to \$1 463,000 as of December 31 1947 and reserves for deferred maternity benefits amounted to \$997 000 as of that date.

A round table conference on medical care insurance will be conducted at the Annual Meeting of the Medical Society of the State of New York on Tues-

day, May 18, 1948, at 3 30 P.M.
Dr. A. II Aaron chairman of the Subcommittee on Medical Expense Insurance of the Council Committee on Economics will act as moderator

moderator
Dr Carlton E. Werts, president of the Western
New York Medical Plan Buffalo will discuss
Benefits Officred by Voluntary Nonprofit Medi
cal Care Plans in New York State 'Dr Milton
J Goodfriend, member of the Board of Directors, United Medical Bervice New York will speak
on the Advantages of a Service Contract for
Low Income Subscribers' a report on the 'Progress
of Voluntary Nonprofit Medical Care Insurance
Plans in New York State will be presented by
George P Farrell, director of the Bureau of Medical
Care Insurance of the State Sective and Dr. Her-George P Parten, director of the Bureau of Medical Care Insurance of the State Society and Dr Her-bert H. Bauckus, Buffalo, president of Veterans Medical Service Plan of New York, Inc., will pre-sent 'Homo Town Medical Care of Veterans under Veterans Medical Service Plan, Inc.

A considerable amount of time has been alloted for general discussion and your participation in the discussion is earnestly invited

SCHOOL HEALTH BROCHURE PUBLISHED BY A.M.A.

A new brochure, outlining the relationship of the physician to the school health and physical education program, is now being distributed by the Bureau of Health Education of the A.M.A.

The pamphlet is entitled Physicians and Schools and is the report of the National Conference on this subject held at Highland Park Illinois in October

1947

Recommendations are made on school health services, school health studies inservice and preservice education and medical guidance in physical education and athletics.

A compilmentary copy will be sent to physicians teachers and public health workers on request. Additional copies are 25 cents each.—Secretary's Report A.M.A. February 8 1948

ASKS SCHOOL FUND FOR DOCTORS CHILDREN

Since death or disability of a physician may pre-maturely end the education of his children organized medicine should be ready to help. This is the sug-gestion of Dr. Elmer Hess, president of the Ponnsyl-vania State Medical Society. He recently asked his

own society and its auxiliary to raise \$500 000 for a special educational fund. He recommends that each of its 10 000 members contribute \$10 a year for five

-Medical Economics January 1948

MEDICAL NEWS

New Health Motion Pictures Available

E IGHT new films have been added to the Department of Health's circulating library of health motion pictures. These films, all 16 mm with sound, will be loaned for showing in New York State. Requests should be addressed to the Supervisor of Visual Instruction, New York State Department of Health, 18 Dove Street, Albany 6, New York. The films are Your Children and You In black.

The films are Your Children and You In black and white, running time 30 minutes Presentation of parent-child relationships dealing with children from early months to school age Covers a variety of subjects weaning, behavior, toys, early questions about sex, fear, discipline, and other major prob-

ems

Something You Didn't Eat In black and white, running time 9 minutes Emphasizes the importance of well-balanced diet containing the basic seven groups of foods and the relation of diet to the main-

tenance of health and efficiency

Time Out In black and white, running time 20 minutes The story of an average young man and tuberculosis, showing his problem from the time vary led to the discovery of the disease up to his ulti-

mate discharge from the hospital Prepared primarily for patients in sandtoria

The Story of Menstruction In black and white, running time 10 minutes Intended for showing to groups of adolescent girls to explain the physiology of menstruction

Know Your Baby In color, running time 10 minutes Illustrates approved methods of care of the new baby in the home where other children are present. It describes the necessary family adjustments, states the rules, and demonstrates how best to apply them.

The Web of Life In color, running time 25 minutes Stresses known facts concerning cancer, describing the early symptoms, diagnosis, and methods of treatment Suitable for general audiences

Miracle in Paradise Valley In black and white, running time 35 minutes A safety film, with a Hollywood cast, of interest to all who farm It suggests

ways of avoiding farm accidents

Magic Food In color, running time 10 minutes
Uses the seven basic foods as subjects for a magic

presentation

Scholars in Medical Science Announced by Markle Foundation

SIXTEEN young scientists, four of them for study in New York colleges, have been appointed as the first group of "scholars in medical science" by the John and Mary R. Markle Foundation under its plan to support qualified young scientists who wish to make a career in academic medicine

Those appointed for study in New York State are Dr Henry H Balch, New York University College of Medicine, for research in the field of surgical infections, Dr William D Lotspeich, Syracuse University College of Medicine, kidney physiology, Dr Frederick D McCandless, Albany Medical College, neuropsychiatry, and Dr Richard C Fowler, University of Rochester School of Medicine, physiology and physicochemical tools

As faculty members of the participating medical schools, the scholars will devote the next five years to teaching and research, at the end of which time they will have had an opportunity to become established teachers and investigators. The Foundation has allocated a total of \$400,000 to the respective medical schools, each school to receive \$25,000 payable at the rate of \$5,000 annually for five years.

According to John M Russell, executive director of the Foundation, an undetermined number of scholars will be appointed each year for the next few years for the long-range purpose of strengthening the faculties of medical schools and medical education generally

Expectant Mothers in State on Poor Diet

ONLY 21 per cent of New York's expectant mothers get enough proteins in the food they eat, the

State Health Department has announced

A survey among 1,567 women by the State Food Commission showed, however, that upstate mothersto-be are better fed than those in New York City "In some instances," the report said, "the amount of income materially affected the quantity and kinds of food in the diet"

Only 21 per cent of the expectant mothers ques-

tioned received the recommended daily 80 grams of protein. In New York City, only 14 per cent got enough, while 26 per cent of the upstate women reported adequate protein consumption

The report, released by Dr Herman E Hilleboe, Health Commissioner, said that 11 per cent of the women interviewed had had no milk on the day of the interview A quart a day is recommended. In New York City, 17 per cent customarily drank no

mılk

Mary Putnam Jacobi Fellowship

THE Women's Medical Association is offering a Putnam Jacobi Fellowship for medical research for 1948. The fellowship of \$1,000 is open to any woman doctor, either American or for-

eign, who is a graduate of a reputable medical school Application blanks may be obtained from the secretary of the Fellowship Committee, Dr Isabel Scharnagel, 139 East 36th Street, New York City 16

Dr Mustard Stresses Tuberculosis Aid

OMMISSIONER of Health Harry 8 Mustard reported in March that New York City's 18,000 tuberculous patients included 7 700 now cases of which only 17 per cent were in the minimal stage where most good could be done while 48 per cent were in the advanced stage. He spoke at the annual joint conference of the New York Tuberculosis and Health Association and the Tuberculosis Sanatorium Conference of Greater New York.

Four bundred delegates representing medical associations, hospitals, health departments and wel fare organizations along the eastern scaboard from New England to Washington attended the all-day seasion. They heard and discussed papers by twenty authorities on tuberculosis social hygiene juvenile delinquency venereal disease health education and

related aubicots

Dr Mustard said \$1,000,000 of his department s budget request of \$15 000 000 for the coming fiscal year was for tuberculosis. About \$028,000 was used for that purpose last year "If we get what we ask," he commented 'we shall be on the way of going out and finding tuberculosis instead of waiting for it to collide with un.

The commissioner explained that \$309 000 was needed for purchase of new equipment and familities

for detection of tuberculosis

A reduction of 5 per cent in the death rate from tuberculosis in New York in 1947 was reported by Godina J Drolet, statistician for the association | He said Health Department figures showed that for the first time deaths had fallen below forty to 100 000 of

population.

Variations in the death rate in the boroughs ranged from 27 8 in Queens to 73 1 in Manhattan with 29 2 in the Bronx 28.1 in Brooklyn, and 410 in Richmond The rate for New York City was 39 6

Dr. Martin H. Collier superintendent of the

Camden County Tuberculosis Hospital at Camden New Jersey was re-elected president of the Tuber culosis Sanatorium Conference. Dr Kendall Emer son, recently re-elected president of the New York Tuberculosis and Health Association presided at the meeting.

Occupational Health Institute Held

THE Institute for Occupational Health of the Long Island College of Medicine presented the fifth in a series of intensive postgraduate courses in industrial medicine from April 5 to April 16 Arranged primarily for physicians, the course was attended also by nurses industrial hygienists and engineers personnel workers, representatives of management and labor and others interested in health in relation to occupation

The Industrial Medicine Advisory Committee who directed the planning and arrangement of the course was composed of Drs. John J Wittmer S Potter Bartley Jean A. Curran Thomas D Dublin Lydia G Giberson Irving Gray, Anthony J Lanza McIville II Manson Frederick H Shillito and L. Holland Whitney

Also on the committee were Henry D Sayer and

J Dowey Dorsett.

The Louis Livingston Seaman Fund

THE New York Academy of Medicine announces the availability of The Louis Lavingston Seaman Fund for the furtherance of research in bacteriology and sanitary science. One thousand two hundred dollars is available for assignment in 1948.

This Fund has been made possible by the terms of the will of the late Dr Louis Livingston Seaman and is administered by a committee of The New York Academy of Medicine under the following

conditions and regulations

The committee will receive applications

either from institutions or individuals up to April 15 1948. Communications should be addressed to Dr Wilson G Smillie chairman of the Louis Livingston Scaman Fund 1300 York Avenue, New

York City 21
2 The Fund will be expended only in grants-in aid for investigation or scholarships for research in bacteriology or sanitary science. The expenditures may be made for securing of technical help aid in publishing original work, or purchase of necessary books or apparatus.

The Edward N Gibbs Memorial Prize

IT IS announced by the New York Academy of Medicine that a sum of \$2 000 is available under the Edward N Cibbs Memorial Prize for original research during 1948 in diseases of the kidney

Candidates must be physicians who have been graduated at least three years and are residents of the United States. They shall submit evidence of research already performed and of facilities to prosecute research upon the causation pathology and new methods of treatment of diseases of the kidney

Applications with the required evidence should

Applications with the required evacence anough be addressed prior to April 15 to
Dr Walter W Palmer, chairman, The Gibbs Prize Committee The Public Health Research Institute of the City of New York William Halleck Park Laboratory East 16th Street, New 1 ork City 9

VA Needs Army and Navy Physicians

HE Veterans Administration in New York is poking for forty-five doctors to replace Army and y medical officers who will leave its hospital is on or about July 1

he uniformed doctors, it was announced in rch, will have finished the two years of service word for medical education received in the ed forces The vacant posts will pay from \$4,100 to \$11,000 a year and call for general medical and surgical practitioners, specialists in tuberculosis, surgery, and neuropsychiatry

The positions expected to be open are in seven Veterans Administration hospitals in New York

State

Doctors interested should apply to the Branch Medical Director at 346 Broadway

City Handbook on Child Care Available

HE New York City Department of Health, issisted by psychiatrists and educators, has preed a 136-page handbook on baby rearing which all send free of charge to parents having a first d It contains advice for fathers as well as there on the theory that "even a tiny baby" his eye on papa

Iavor William O'Dwyer has written an introduc-

tion extending the city's official greeting to new parents and assuring them that the municipal government is "deeply interested in your family's welfare" The instructive material was prepared by the Bureau of Child Hygiene and various specialists under the supervision of Dr Leona Baumgartner, director of the bureau Parents can write or call the bureau for their copy

Thirty-one Schools Get \$435,706 to Aid Cancer Teaching

RANTS to aid cancer-teaching programs in thirty-one medical and dental schools were ounced in March by the Federal Security Agency grants total \$435,706 and are from funds of the tional Cancer Institute of the United States plic Health Service among four-year medical school grants were the following president and fellows of Harvard College, Boston, \$25,000, Albany Medical College, \$24,717, Long Island College of Medicine, Brooklyn, \$24,948, University of Buffalo School of Medicine, \$25,000, Cornell University Medical College, Ithaca, \$24,975, and Woman's Medical College of Pennsylvania, Philadelphia, \$24,958

MEETINGS

PAST

ierican College of Allergists

Approximately 500 physicians from all parts of United States and several foreign countries took t in the fourth annual scientific session of the ierican College of Allergists, held from March 12 14 in New York City

Among the speakers presenting scientific papers re Dr Otto Loewi, New York City, on "Transsion of Nervous Impulse," and Dr Philip McMaster, associate member of the Rockefeller titute for Medical Research, on "Anaphylactic ock in Mice Induced by Traceable Antigen"

sociation for the Advancement of Psychorapy

'The Psychopathology of Comic Books' was cussed at the meeting of the Association for the vancement of Psychotherapy on Murch 19, with akers including Dr Hilda L Mosse and Dr Irvin L Blumberg Dr Frederic Wertham induced the symposium speakers

At a special meeting on April 9, Dr Alfred C nsey spoke on "A Comparison of Sexuality in ile and Female" His paper was discussed by a Abraham Stone, Sophia J Kleegman, and bert L Dickinson

Syracuse Academy of Medicine

Arranged by the Council Committee on Public Health and Education of the State Society, post-graduate instruction was presented for the Syracuse Academy of Medicine on March 16 at the Syracuse University College of Medicine Dr Joe W Howland, chief of the division of medical services, University of Rochester School of Medicine and Dentistry, spoke on "Medical Aspects of the Atomic Bomb"

Saranac Lake Medical Society

With Dr E N Packard and his staff in charge, a Trudeau Sanatonium program was presented at the meeting of the Saranac Lake Medical Society March 24

Eastern New York Eye, Ear, Nose and Throat

Dr Charles Hendee Smith, New York City, spoke on the "Relation Between Pediatrics and the Specialty of Eye, Ear, Nose, and Throat" at the Meeting of the Eastern New York Eye, Ear, Nose and Throat Association, held April 1 in Schenectady

FUTURE

University of Buffalo School of Medicine

The eleventh annual clinical day of general meetings of the Alumni Association of the University of Buffalo School of Mediene will be held Saturday, April 17 at the Hotel Statler Buffalo All physicians are invited to attend the clinical

lectures With Dr Ramsdell Gurney presiding, the morn-ing sessions will include the following speakers and papers Dr John D Stewart, professor of surgery University of Buffalo, "The Problem of Massive Hemorrhage from Peptic Uler" Dr Frances Eugene Senear, professor of dermatology and apphilology University of Illinois, Euptions Due to Drug Administration Dr Nolan D C Levis professor of psychiatry Columbia University Proceedings for the General Practitioner, Proposition of the Control Processor of orthopedic surgery New York Polycline Medical School, Differential Diagnosis of Low Back Disability and Cases Simulating Posterior Herniation of the Intervertebral Disk, and Dr Mortimer N Hyams associate professor of clinical gynecology Columbia University, "The Recognition and Management of Gynecologic Conditions from the Standpoint of the

At the afternoon session Dr L. Maxwell Lockic will preside The program will include Dr Howard Dayman, associate in medicine University of Buffalo, The Importance of the Larl, Recogni-tion of Pulmonary Disease Dr James L Wilson, professor of pediatrics University of Michigan The Clinical Diagnosis of Respiratory Symptoms in Infancy Dr Elmer C Texter vice-president, American Academy of General Practice, The General Practitioner and the American Academy of General Fractioe Dr John A Kolmer professor of medicine, Temple University "The Synergistic or Additive Activity of Chemotherapeutic Com-pounds, and Dr Alvan L. Barach associate pro-fessor of clinical medicine, Columbia University Antibotic Therapy in Bronchopulmonory Dis-

Buffalo Surgical Society

Active Practitioner

On Saturday night, April 17, at the Kleinhans Music Hall, Buffalo the Roswell Park Locture and presentation of the Roswell Park Medal will be

sponsored by the Buffalo Surgeal Society
Recipient of the medal will be Dr Allen O
Whipple, omeruts Valentine Mott professor of
surgery Columbia University, 1946 and clinical
director Memorial Hospital, New York City His
address will be Factors Determining the Safety of Present Day Radical Surgery

Four County Clinic Day

The annual Four-County Clinic Day, sponsored the Medical Societies of Genesee Livingston

by the Medical Societies of Genesse Livingson Orleans, and Wyoming counties, will be held Wed-nesday April 21 at the Hotel Sheraton, Rochester The program will include "The Early Recogni-tion of Postoperative Venous Thrombosis, Dr Earl B Maboney assistant professor of surgery, University of Rochester School of Medicane and Dentistry subject to be announced, Dr Will Cool Spain, clinical professor of medicine New York Post-Graduate Medical School "The Inter pretation of Jaundice in the Surgical Diagnosis. Dr Samuel Standard, assistant professor of clinical surgery New York University College of Medicine Indications, Limitations and Abuses of Endocrine Therapy in Cynecology "Dr Emil Novak associate in gynecology Johns Hopkins Medical School Treatment of Common Fractures, Dr Henry H Ritter professor of clinical surgery, New York Post-Graduate Medical School and The Neurosis Related to the Manic Depressive Constitution Dr Foster Kennedy professor of clinical medicine Cornell University Medical

Mount Sinai Hospital

College.

In affiliation with Columbia University College of Physicians and Surgeons, a refresher symposium in ophthalmology will be given by the ophthalmologic and medical staffs of Mount Sinal Hospital during the four week period of April 26 through May 22 Designed to be an intensive review of modern concepts in the field it will consist of clinical laborators and didactic instruction in pathology embryology

bacteriology, optics surgery ophthalmoscopy, etc.
The class will be limited to eight qualified oph Further informa thalmologists it is announced tion about the course may be obtained from the registrar of medical instruction at Mount Sinai Hospital or at the office of the dean, Columbia University College of Physicians and Surgeons.

American Society for Research in Psychosomatic Problems

The annual meeting of the American Society for Research in Psychosomatic Problems will be held May 1 and 2 at the Challonte-Haddon Hall, Atlantic

May I and 2 at the Chanionte-Lindon Line, Amanu-City New Jersey

The following physicians from New York State
will participate in the program Dr Flanders
Dunbar "Psychosomatic Aspects of Genitourinary
and Gynecologic Problems" Dr Adrian H.
Vander Veer "Psychosomatic Aspects of CardioAs Schwarts, Psychosomatic Aspects of Cardiospasm with Case Presentation, Dr Rene A.
Spits Bomatic Concomitants of Emotional Vicisstudes in Infancy" Dr Edward Tolstol "The
Oblicatives of Modern Diabetic Caro" and Dr Objectives of Modern Diabetic Care' and Dr George E Daniels The Role of Emotion in the Onget and Course of Diabetes.

Dr Frans Alexander will serve as chairman for the panel discussion on 'Problems of Methodology in Psychosomatic Research

Practical Nurses of New York, Inc.

The third annual convention of Practical Nurses of New York Inc. will be held from May 10 to 21 at the Henry Hudson Hotel, New York City The main open session is scheduled for Thursday May 20 with a banquet in the evening

American Physical Therapy Association

The annual convention of the American Physical Therapy Association will be held from May 23 to May 28 at the La Salle Hotel, Chicago, Illinos. Speakers scheduled include Dr. Hart E. Van Riper medical scheduled include Dr. Hart E. Van Riper medical director of the National Foundation for Infantile Paralysis. Dr. Louis B. Newman chief of physical medicine rehabilitation Veterans Administration Hospital, Hines Illinous, Dr. Sumuer L. Łoch, professor of surgery, Northwestern University Medical School. Dr. Harry D. Bowman professor of physical medicine, University of Wisconsin, Dr. Stafford L. Osborne. associate professor of physical medicine, Vorthwestern University. Dr. physical medicine, Northwestern University. physical medicine Northwestern University, Dr Robert L. Bennett director of physical medicine

Georgia Warm Spr ngs Founda ion, and Drs David I Abramson and Geza de Takats, from the University of Illinois

St. Francis Sanatorium for Cardiac Children

A postgraduate course in rheumatic fever and rheumatic heart disease will be held at the St Francis Sanatorium for Cardiac Children, Roslyn, Long Island, from June 1 to June 15 The fee for the course is \$75

Applications should be submitted before May 1, and further information may be had by writing Rev Mother Superior, F M M, at the Sanatorium

National Foundation for Infantile Paralysis

The National Foundation for Infantile Paralysis will celebrate its tenth anniversary by sponsoring the First International Poliomyelitis Conference from July 12 to July 17 at the Waldorf-Astoria Hotel, New York City

Purpose of the Conference is to coordinate and

evaluate the last decade of progress that medical science has made in the study of the disease, and it will be the first time that information on poliomyelitis, its treatment and research will be exchanged internationally on such an extensive basis. The Conference will bring together the world's outstanding laboratory and clinical authorities on poliomyelitis. Assisting the National Foundation are leading international medical and scientific institutions interested in combatting the disease.

International Society of Hematology

The biannual meeting of the International Society of Hematology will be held at the Hotel Statler, Buffalo, from August 23 to August 26, and will include scientific sessions and exhibits

Chairman of the program committee is Dr Ernest Witebsky, Buffalo General Hospital Applications for the presentation of scientific exhibits are now being received by Dr O P Jones, department of anatomy, University of Buffalo

PERSONALITIES

Retired

After fifty-seven years of practice in New York State, Dr Heinrich Leonhardt, a graduate in 1890 of the University of Buffalo Medical School, retired last year and has moved to St Petersburg, Florida Formerly on the staff of DeGraff Memorial Hospital, North Tonawanda, Dr Leonhardt was a member of the Medical Society of the State of New York, the Buffalo Academy of Medicine, the Niegara County Medical Society, the Twin City Academy of Medicine, the American Medical Society of Vienna, and an honorary member of the American Medical Association

Honored

The late Dr John M Collins, former president of the Schenectady County Medical Society who died January 25, honored by a resolution commemorating the memory of "his lovable nature as a man and his tireless zeal as a physician" Dr Roswell Park, who served until his death in 1914 as professor of surgery in the University of Buffalo Medical School, in whose honor the Roswell Park Lecture and the Roswell Park Medal to pay tribute to the foremost surgeons of the nation has been established by the Buffalo Surgical Society

The late Dr George Barclay Wallace, research authority and founder of the Department of Pharmacology at the New York University College of Medicine, in whose memory the Alumni Association of the College has inaugurated a campaign to raise \$250,000 for the creation of the Wallace Laboratories for research in pharmacology at the New York

University-Bellevue Medical Center

Appointed

Dr Richard T Beebe, dispensary physician-in-charge at the Albany Hospital's outpatient department, as professor of medicine and director of the department of medicine at Albany Medical College, effective July 1 Dr Vincent DePaul Juster, Jamaica Estates, as a member of the State Board of Social Welfare, designated by Governor Dewey for a five-year term to succeed Dr Joseph F Todd, Brooklyn Dr Freddy Homburger, New York City, an associate of Memorial Hospital's Sloan-Kettering Institute for Cancer Research and

head of the department of clinical investigation, to the new research professorship of medicine in the department of surgery at Tufts College Medical School, Boston, Massachusetts He also will head cancer research and cancer control at the college, the new cancer unit being one of the first set up in an American medical college under the United States Public Health Service

Lieutenant Colonel Charles W Hutchings, assistant director of the Manhattan State Hospital, Ward's Island, New York City, as new commander of the 444th Hospital Ship Complement, Organized Reserve Corps, New York City Dr Clinton P McCord, Albany, as consultant in psychosomatic medicine to the State Department of Health In announcing the appointment, Dr William A. Brumfield, deputy commissioner, cited a need for increased attention to emotional disturbances, both as a cause and as a complication of physical disease, emphasized that Dr McCord's appointment is intended to provide the Department with consultation regarding emotional and psychologic factors in diseases and conditions already a part of the Department's responsibility

Colonel Peter Manjos, physician at the Northport Veterans Administration Hospital, Long Island,
as new commander of the 367th Medical General
Laboratory, Organized Reserve Corps, 'New York
City Lieutenant Colonel Christopher Parnall,
Jr, Rochester, as new commander of the 347th
Mobile Surgical Hospital, Organized Reserve Corps,
Rochester Dr Samuel M Wishik, formerly head
of the division of physically handicapped children of
the New York City Health Department, named to
the United States Children's Bureau of the Federal
Security Agency to direct the planning work connected with the Bureau's program of grants-in-aid to
the states for maternal and child health, and for
crippled children's services

Elected

Dr William G Childress, physician-in-charge, tuberculosis division, Grasslands Hospital, Valhalla, as vice-chairman of the Tuberculosis Sanatorium Conference of Metropolitan New York Dr Stanford Pulrang, Yonkers, vice-president of the Yonkers Academy of Medicine and a member of

[Continued on page 940]

NECROLOGY

Abraham Arden Brill, M D , New York City, died on March 2 at the age of seventy three. A native of Austria, Dr Brill was graduated from College of Physicians and Surgeons Columbia University in 1903 After four years as an assistant physician at the Control Islip, Long Island State Hospital he studied abroad under Dr Carl Jung at Zurich and under Dr Sigmund Froud at Vienna In 1908 Dr Brill returned to the United States bringing public attention to psychoanalysis with his translations of the works of Froud, the first of which Selected Papers on Hysteria appeared in 1909

He became chief of the clinic in psychiatry at Columbia University in 1911 and at the outbreak of World War I he was also lecturing at New York University New York Post-Graduate Medical School, and the New York State Psychiatric Insti-tute During the war he trained psychiatrists in the Army Medical Corps In World War II he was con sultant on neuropsychiatry at the Selective Service Induction Center at Grand Contral Palace He was also consultant to the psychiatric departments of Bellevue, Manhattan State, and the Kingsbridge Veterans' Administration hospitals

Dr Brill was the founder of the New York Psy choanalytic Society, and a founder and former president of the American Psychoanalytic Associa tion He was also a member of the American Psychiatric Association New York Academy of Medicine, New York Society for Chnical Psychiatry American Therapeutic Society American Association for the Advancement of Science New York Psychoanalytic Institute, American Medical Association and New York State Medical Society

In 1929 Dr Brill became a member of the execu tive committee of the New York State Committee on Mental Hygiene, and continued active until his death He also served for several years on the Com-

mittee on Mental Hygiene Legulation

Besides translating the works of Freud and Jung Dr Brill was the author of many original works on psychoanalysis These included Psychoanalysis— its Theories and Practical Application Fundamental Conceptions of Psychoanalysis Lectures on Psycho-analysis and Psychiatry, and Freud's Contributions to Psychiatry

Frank Hough Carber, M.D., died at his home in Middlesex on February 28 He was sixty two years of age Dr Carber had been a medical director of the Mutual Life Insurance Company of New York since 1921. Graduating from College of Physicians and Surgeons, Columbia University 1912, he interned at New York Post-Graduate Hospital and the Mayo Clinic, Rochester Minnesota. Dr Carber was the author of several medical works, including Present Status of Gotter and Fifteen 1 ears of Gotter Underwriting

John H. Collins, M.D., seventy-eight, died on January 25 at his home in Schenectady He was the first health commissioner of Schenectady holding that post from 1920 until 1930 Dr Collins was city health officer from 1918 to 1920 when the municipal health bureau was raised to a department. He also served as deputy commasioner from 1037 to 1038
He was formerly chief of staff of City Hospital
physician for the Day Nursery and Children a Home
and a member of the consulting staff at Elis Hopltal where he headed the gynecologic staff for more than twenty five years The City Hospital was

reorganized and rebuilt under his administration, and for five years he was managing director of the institution A pioneer in the movement for establishment of a crippled cluldren's hospital in Schenectady he was recently re-elected to a three-year term on the board of directors of Sunnyview where he

was at one time staff surgeon.

In 1897 Dr Collins was graduated from the University of Vermont College of Medicine and later did graduate work in hospitals in Vienna, Loipzig Berlin, and London He was a fellow of the American Public Health Association and a member of the American Medical Association the New York State and Schenectady County medical societies Last June, Dr Collins was honored by the county society for his fifty years of active practice. He was a member of the White House National Conference

on Child Health Charles A. Elaberg, M.D. seventy-six, died in Stamford Connecticut, on March 18. He was a graduate of the College of Physicians and Surgeons, Columbia University in the year 1893 A fellow of the American College of Surgeons and one of the founders of the Neurological Institute of the Columbia Presbyteman Medical Center, Dr Elsberg was especially noted for his study to devise a method for the determination of the presence of brain tumors by the reactions of the special sense organs. He was a consultant surgeon at the Plower and Fifth Avenue Anickerbocker Monteffore and Mt Smar hospitals in New York and for Vassar Brothers Hospital in Poughkeepsie Dr Elsberg was director ementus of the Neurological Institute at the time of his death and an honorary member of the Societe Interna tionale de Chirurgie and the Societa Radio-neurochirurgical Italiana. He also belonged to the American Neurological Association the Academy of Medicine the New York Neurological New York Pathological, and New York Surgical societies, the American Medical Association and the New York

American Association and the New 10th State and New York County medical securities

Philip J Genthner, M D, Brooklyn died at lus home on March 9 He was cight; five years of ago

Dr Genthner graduated from New York University

School of Medicine in 1888 He had been associated with the New York County and the New York with the Methodist Hospital Brooklyn and was chief medical examiner for the Royal Arcanum for more than thirty years Dr Genthner was also a member of the New York State and Kings County medical societies and the American Medical Associa

Alberta F M Green, M.D., aged seventy-seven of New York died on March 8 Dr Green, who was retired, graduated from the College of I hysicians and Surgeons, Columbia University in 1902 and practiced in Kansas City Missouri before coming to New York She had served on the staff of the State Prison for Women in Bedford Hills New York and did hospital work for the American Red Cross in

Belgrade, Yugoslavia after World War I James Taylor Harrington, M.D., of Poughkeepsie died on February 27 at his home. He was soventy years old. Dr. Harrington graduated from the died on remain 2 for the years old Dr Harington graduated from the College of Physicians and Surgeons, Columbia University in 1906 and interned at Rossevit and Sleane hospitals, New York Former superintendent and chief surgeon at Vassur Brothers Hospitals, the second the surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second standard surgeon at the second surgeon surgeon at the second surgeon surgeon surgeon surgeon surgeon surgeon surgeon surg pital Poughkeepsie he was attending surgeon at that hospital until he retired in 1942. He also served as consultant surgeon for the North Dutchess Health Service Center, Rhinebeck, Hudson River State Hospital, Poughkeepsie, Highland Hospital, Beacon, and Sharon Hospital, Sharon, Connecticut Dr Harrington, a fellow of the American College of Surgeons, served as a member of the Medical Reserve Corps in World War I and had been director of the Dutchess County Health Association A former member of the Board of Health, past president of the Poughkeepsie Academy of Medicine and the Dutchess County Medical Society, he was a member of the American Medical Association and the Dutch-

ess County and New York State medical societies
John Francis Ryan, M D, fifty-five, of Brooklyn,
died on March 21 Dr Ryan was graduated from
Queens University Medical School, Kingston,
Ontario, in 1915 He was on the staff of St Peter's Hospital, Brooklyn, and was a member of the American Medical Association, the Celtic, New York

State, and Kings County medical societies
John Trotter, M D, of Troy, died in February at
the age of seventy-three In 1898 he received his medical degree from the University of Vermont He was attending surgeon at Samaritan Hospital, Troy, from 1919 until his retirement two years ago also had served as consulting surgeon at the Mary McClellan Hospital in Cambridge, Massachusetts, surgeon-in-chief at Putnam Memorial Hospital, Bennington, Vermont, and surgeon at Vanderhyden Hall, Troy

Henry Morris Weisman, M D, the Bronx, died on March 16 He was sixty-two years of age He was

attending pediatrician at Bronx Hospital and assistant pediatrician at Mount Sinai Hospital, New York City Dr Weisman was graduated from the University of Bellevue, now New York University College of Medicine, in 1910 He was president of the Bronx Pediatrics Society and a member of the New York State and Bronx County medical societies, and the American Medical Association

Charles S Winters, M D, of Binghamton, died on March 20 Eighty-four years of age, he was the oldest practicing physician in Broome County He was graduated from the New York Homeopathic

Medical College in 1890

Lee Adrian Whitney, M D, of Rochester, died on February 14 at the age of seventy-five A graduate of the University of Buffalo, School of Medicine, in 1901, Dr Whitney was orthopedic surgeon at St Mary's Hospital, honorary surgeon at St Mary's Hospital, and consulting orthopedic at Genesee Hospital, and consulting orthopedic surgeon at the Rochester State Hospital, the Monroe County Infirmary, Rochester, and Craig Colony Hospital, Sonyea Dr Whitney was a member of the Academy of Medicine, the Pathological Society, the American Medical Association, and the Monroe Country and New York State and, and the Monroe County and New York State medical societies

Correction. Owing to an unfortunate confusion of identical names, an announcement of the death of Dr Norbert Neumann, of Ridgewood, Queens, was reported erroneously in the March 1 issue editors extend their apologies to Dr Neumann

Medical News

[Continued from page 938]

the surgical staff of St John's Riverside Hospital, as president of the Yonkers Community Chest Dr John J Quinlan, Troy, president of the Rensselaer County Board of Health, as president of the Troy Country Club

Resigned

After 16 years of service, Dr William J Vogeler, as president of the Yonkers Tuberculosis and Health Association

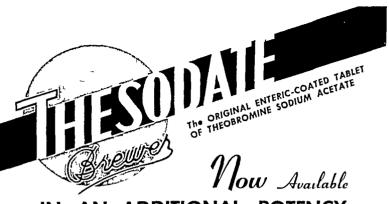
Speakers

Dr A. S Dean, Buffalo, district health officer, on the establishment of a county health department, at a meeting of the Niagara Falls Chamber of Dr Ronald Hamilton, Binghamton, Commerce on "Be Your Age" at a meeting sponsored by the Norwich Business and Professional Women's Club, in Norwich Dr Vrooman S Higby, Bath, president of the Steuben County Medical Society, at a meeting of the Corning Business and Professional Women's Club Dr William D Niederland, psychologist on the staff of Mount Single Herrital chiatrist on the staff of Mount Sinai Hospital, New York City, on "Neuroticism in Individual and Public Life" at a meeting of the City College Evening Session Sociology Society
Dr George T Pack, Pack Medical Group,

New York City, at the annual meeting of the New Orleans Graduate Medical Assembly, New Orleans, Louisiana, lectures before the section on surgery, on "The Endocrinology of Neoplastic Diseases," "The Definition of Inoperability of Cancer," and "The Diagnosis and Treatment of Tumors of the Soft Somatic Tissue" Dr William A Petry, Catskill, president of the Greene County Medical Society and director of the county Tuber-culosis and Health Association, a radio broadcast on the findings in mass x-ray services given in many Greene County areas since 1944 Dr Wesley T Pommerenke, Rochester, at a meeting of the Planned Parenthood Center in Buffalo

New Offices

Dr Stephen L Daly, who served in the US Army in World War II as chief of obstetrics and Army in World War II as chief of obstetrics and gynecology in Nuremburg, Germany, practice of obstetrics and gynecology in Freeport Dr George F Emerson, US Navy veteran, practice of dermatology in Schenectady Dr Willis E Hammond, New Berlin, Army Medical Corps veteran, general practice in Earlville Dr George G Miles, Brooklyn, Army veteran, general practice in Downsville Dr Ronald P Smith, Water-town practice of orbithalmology in Plettsburg town, practice of ophthalmology in Plattsburg



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HOSPITAL NEWS

Research Project to Aid Disabled

A NEW research program to help crippled men and women find a normal life by an accurate scientific analysis of their disability, and the jobs they can and cannot do, has been set up through the joint efforts of the Columbia University School of Public Health and Goodwill Industries of New York, Inc., it was announced in March

The two institutions are cooperating to run what is believed to be the first "fatigue laboratory" for studying handicapped individuals Columbia furnishes graduate physicians and nurses to conduct the program and will use it as "an important training center"

Dr Leonard J Goldwater, professor of industrial

hygiene at Columbia, is director of instruction and

research for the new program

The objectives of the study are to determine the physical demands of specific jobs in relation to the capabilities of persons with specific limitations as a result of accident or illness

This is a relatively new field, Dr Goldwater said, and there are no generally accepted standards for measuring the extent of damage to individual ability as a result of crippling "Results of the research will undoubtedly aid many thousands of disabled men and women who will be considered useless and unemployable until science finds out the kind of jobs they are capable of doing." Dr Goldwater declared

First Class for Men Student Nurses Since War Opens at Bellevue

TO MEET a growing need for men in the field of nursing, it was announced by the office of Dr Edward M Bernecker, Commissioner of Hospitals, that the first postwar class of men student nurses would be admitted March 31 to the Mills School of Nursing for Men of the Bellevue Hospital School of Nursing

No classes have been admitted to the Mills School since September, 1942 The first class has twenty students and the September class will be

able to accommodate forty men students

Dr Bernecker said he hoped the nursing course would interest veterans who had served during the war in the Medical Corps The student gets \$20 per month as a working scholarship and veterans get

additional benefits under the GI training program
In 1942 the Bellevue School of Nursing became
part of the Division of Nursing of the New York University College of Medicine It offers a threeyear program of study leading to a certificate in nursing and a five-year program for a Bachelor of Science degree

The Mills School was established in 1888 by Darius Ogden Mills, father of the late Mrs Whitelaw Reid and grandfather of the late Ogden Mills, former Secretary of the Treasury The Mills School and the Bellevue School operated as separate units until 1939 when they were consolidated

Child Mental Hygiene Center at Adelphi College

A CENTER was opened in March by Adelphi College for the treatment of emotionally dis-turbed children, Dr Paul Dawson Eddy, president of the college announced

The center will offer psychiatric and psychologic services to Nassau County children and their parents on a fee schedule It will be open Mondays through Fridays, 9 to 5 P M , and will accept referrals

from social agencies

Four major goals have been set up by the Children's Center, according to the statement by Dr Eddy The first is the professional treatment of "a limited number" of emotionally maladjusted

Closely allied is the second aim of rechildren search in the psychiatric treatment of juvenile delinquents and other disturbed children. The third and fourth goals, affecting the college principally, are an opportunity for field work and laboratory experience for graduate students, physicians, and nurses, and an improvement of the entire college program through mental hygiene
Dr John C Thurrott, a practicing psychiatrist

of New York City, is the medical director Ella A Dye, formerly with the Psychiatric Clinic of the Manhattan Children's Court, has been appointed

psychiatric social worker

\$588,032 Public Health Funds Given for Cancer Study

FIFTY-ONE cancer research grants, the largest number ever given out of Public Health Service funds at one time, were announced in March by Oscar R Ewing, Federal Security Administrator

Among research projects totaling \$588,032, the largest sum, \$90,960, went to Johns Hopkins University in Baltimore, more than half of it earmarked for an investigation of mass x-ray methods for early detection of cancer of the stomach

To Harlem Hospital, New York City, where 611 proved cancer cases were treated last year, went \$20,000 for a large-scale project in chemical analyses of the blood and in testing out various agents for cancer treatment

Other New York institutions receiving grants were Cornell University, Columbia University, New York Zoological Society, Memorial Hospital, Fordham University, and University of Rochester

[Continued on page 944] 942



[Continued from page 942]

Two Medical Centers Agree on a Merger

OFFICIALS of the projected \$15,575,000 New York University-Bellevue Hospital Medical Center and the New York Post-Graduate Medical School and Hospital have adopted a "proposed plan" to merge the properties and programs of the two institutions, it was announed in March

Dr Harry Woodburn Chase, chancellor of New York University, and Charles S McVeigh, chairman of the Executive Committee of Post-Graduate issued a joint statement, outlining a basis for legal procedures necessary to carry out the plan and also providing for the establishment of a new College of Graduate and Postgraduate Medicine as a unit of the New York University-Bellevue Hospital Medical Center

The statement said the proposed union was originally suggested by Rush H Kress, vice-president of the Samuel H Kress Foundation, which announced last November a "contingent contribution"

of \$1,000,000 to the medical center

Mr McVeigh, in a statement read at the dinner on behalf of the trustees of Post-Graduate, noted that the projected merger was inspired by the recommendation of the Hospital Council of Greater New York that an over-all plan for the city's hospitals be adopted The Hospital Council stressed the need for central teaching hospital facilities and teacher training opportunities for all of the New York hospitals

Mr McVeigh said the merger of the two medical organizations would result in increased opportunities for postgraduate teaching through Bellevue Hospital and other affiliated and regional hospitals

The announcement said the Medical Center and the Post-Graduate Medical School and Hospital would combine their buildings, programs, and assets The Medical Center will continue to function at the NYU College of Medicine, until new Medical Center buildings are erected

News Notes

Faxton Hospital, Utica, admitted 5,310 patients and gave 43,272 days of hospital care in 1947, according to a recent report by Leonard Lubbock, superintendent An average of 118 patients were cared for daily, so that 77 per cent of hospital beds were constantly occupied. In surgery, there were 3,375 operations of an average of nine a day A total of 916 live babics were born with no maternal deaths X-ray examinations totaled 2,677, and 1.851 outpatients were given care

The Society of the Hillside Hospital has adopted a proposal to erect new buildings at the hospital in Bellerose, Queens, and construction will start this summer, it was announced by Dr Israel Strauss, president of the organization, at the annual meeting, Under the plan, the capacity of the held in March hospital, which treats curable mental cases, is to be enlarged from 90 to 170 persons. Some of the additional facilities are to be used for a psychiatric clinic for adolescent girls

A hospital survey committee of the Delaware County Medical Society has advocated construction Incorporated in 1882 and chartered four years later, the New York Post-Graduate Medical School and Hospital was organized by an association of faculty members from the New York University Medical School to offer greater opportunities to practicing physicians for a "continued education" Its annual enrollment numbers 1,100 physicians and specialists from forty-four states and twentyfive foreign countries

Since 1931 Post-Graduate has been affiliated with Columbia University Early last year both institutions announced that they would sever connections effective June, 1948, for "administrative reasons" The postgraduate teaching program at the hospital has been under the supervision of the Columbia University Medical School faculty At present Post-Graduate Hospital has 400 beds and provides medical services for 100,000 outpatient visits annually In addition, it operates the Reconstruction Hospital, also in New York City, which contains a fifty-bed unit and specializes in traumatic surgery as well as maintaining an active outpatient department

The announcement said the merger would enable New York University to broaden its base for postgraduate training and provide an important unit for the Medical Center Five hundred physicians now are enrolled at the University's postgraduate division under a special program aided by the Kellogg Foundation

They represent thirty-two states and twelve foreign countries

Edwin A Salmon, director of the Medical Center, said the center would continue to operate its postgraduate facilities for research, until new buildings He said that the proposed Univerwere erected sity Hospital, a unit of the Medical Center, would be available primarily to persons in the "middleincome group "

of six 50-bed hospitals at points throughout the county, Clark Hillis, chairman of the committee, recently announced

The committee went on record as stating that the need for adequate hospitalization for the county is Mr Hillis explained that if a 50-bed hospital was built in the Walton-Delhi area it would still be impossible for Hancock physicians to make use of its facilities In advocating several hospitals at strategic points, the committee pointed out the county is geographically large and there are many communities that would be a considerable distance from any centrally located hospital

Plans of Binghamton City Hospital to establish an outpatient clinic at the institution have been commended by the American College of Surgeons, according to a report to the board of managers by Dr M T MacEachern, associate director of the college, based upon an inspection made in October by Dr David W Park

Plans of hospital officials were to open the clinic on a limited scale, with only welfare clients eligible for treatment Later, it was indicated, the scope of the clinic would be broadened to permit persons of limited financial means, although not certified



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l. Cooke, J V.: Brennemann Practice of Pediatrics 4: Chaper 41 1945

, et al: J Ped. 31: Oct., 1947 a Sullivan N: Int'l. Congress of

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Zone

[Continued from page 944]

relief cases, to receive treatment. At the clinic, persons who required medical treatment but who were not sick enough to be hospitalized would be treated.

"The Treatment of Chronic Pulmonary Disease" will be the subject of Dr Alvin Barach, assistant professor of medicine, Columbia-Presbyterian Medical Center, at the April 28 lecture at the US Veterans' Hospital, Manhattan Beach, Brooklyn On May 5, Mr Michael Dubin of the Winthrop Chemical Company, will speak on "Endocrines" Dr S Polayes, director of pathology, Cumberland Hospital, Brooklyn, will speak on "Relationship of A and B Factors in Icterus Neonatorum" on May 19 "Amino Acids" is the subject of Dr Donald D Van Slyke, member of the Rockefeller Institute of Medical Research, New York City, on May 26

The meetings are scheduled for 4 PM at the US Veterans Hospital at Manhattan Beach

Drs A. S Effron, James L McLeod, Wesley M Oler, and Laurence I Kaplan were the speakers at the monthly conference at Bellevue Hospital, New York City, on March 30 Discussers were Dr Foster Kennedy, director of the neurologic service, and Dr J Lawrence Pool

"Acute Appendicitis—a Review of 1,334 Cases with Special Emphasis on Mortality Factors" was the subject of Dr Aubre de L Maynard, Harlem Hospital, at the meeting on April 7 of the Harlem Surgical Society Discussers were Dr Benjamin N Berg, visiting surgeon, and Dr Solomon Weintraub, pathologist at Harlem Hospital

Long Island College Hospital has drastically curtailed its Social Service Department, it has been announced by Mrs Mary Childs Draper, chairman of the Social Service Committee The staff has been cut from six to two professional workers, one of whom will handle cardiacs while another will do the most indispensable social service jobs

The cut was forced by financial difficulties, Mrs Draper explained, and in no way indicates lack of conviction as to the value of social work in hospitals. She said efforts would be made to rebuild the de-

partment

Buch

The Cancer Detection Center at the Hudson City Hospital opened in February and was sponsored and approved by the Columbia County Medical Society Physicians making examinations will serve without pay A nominal charge will be made for those who can pay to partially defray cost of laboratory and v-ray work.

Dedication of the new \$1,500,000 wing of St Peter's Hospital, Albany, July 1, will increase to 325 the capacity of the hospital, which has been providing Albany with medical care since 1869 One floor will be devoted to pediatrics and a large department will be opened for the specialized treat-

ment of nose and throat diseases The rest of the wing will be devoted to rooms for patients, additional operating facilities, and extra quarters for interns. Some functions now carried out in the older part of the hospital will be transferred to the new section, and additional bed space will be provided in the older building.

Dr David Rittenberg, associate professor of biochemistry at the College of Physicians and Surgeons of New York, delivered the second lecture in the series of forums on the application of fundamental sciences in medicine in the auditorium of the Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, on March 31 His address was "The Application of Nuclear Chemistry in Medicine"

The first unit of the joint Medical Equipment Development Laboratories of the armed forces was established at Fort Totten Army Medical Center in Queens in February, Colonel David E. Liston, commander of the center, announced. The laboratories will plan and develop medical equipment for the armed forces and conduct research to determine the causes and cures for failure in present equipment. They will consolidate development activities now scattered throughout various installations of the Army and Navy

The Society of Memorial Center for Cancer and Allied Diseases conducted a symposium on cancer in the auditorium of Memorial Hospital Center, New York City, for workers in the women's division of the 1948 Joint Campaign of the New York City Cancer Committees

Doctors, surgeons, and research specialists gave lectures on April 6, 8, 13, 15, 20, 22 and 27, according to Mrs Owen Cates Torrey, chairman of the women's division. The theme of the symposium was "Responsibility, the New World in Cancer."

Dr Edward Miller has announced the closing of his Roscoe Hospital, Roscoe, on February 15 Opened April, 1, 1937, the hospital has taken care of 2,000 patients since then

At the April 5 meeting of the Clinical Society of the New York Polyclinic Medical School and Hospital, New York City, papers were read by Drs Bernard L Cinberg, Jerome Wagner, Hunter H Romaine, Victor L Browd, Charles H Nammack, Herbert C Chase, S Philip Goodhart, Frederick M Allen, Harry C S DeBrun, Irving R Roth, Harry Zuckerman, Otto C Kestler, and Richard Kovacs

Recommendations for a new county hospital for Jefferson county were submitted by Dr Sutherland E Simpson, superintendent of the county sanatorium and the hospital for chronic diseases, in his annual report to the board of supervisors. The 100-bed hospital for treating all types of welfare medical and surgical cases would be built on the

[Continued on page 948]



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[Continued from page 946] present sanatorium grounds, Dr Simpson recommended.

"Recent Studies on Deficiency Diseases" was the subject of the William Henry Welch Lecture, given by Dr Tom D Spies at Mount Sinai Hospital, New York City, on March 31 Dr Spies is chairman of the department of metabolism and nutrition at Northwestern University School of Medicine, Chicago, Illinois, and the director of the Nutrition Clinic, Hillman Hospital, Birmingham, Alabama

A survey conducted by the executive committee of the Schoharie County General Hospital Fund indicates an increasing need for more adequate hospital facilities for the county. In the last five years 2,378 county residents have been hospitalized in Ellis Hospital in Schenectady alone, totaling 21,379 days in this one hospital The Mary Imogene Bassett Hospital in Cooperstown reports that from 1944 through 1947, 588 patients from Scho-haric County have been hospitalized for periods totaling 6,125 days. At the Elmholm Hospital in Cobleskill for an eleven-month period, a total of 431 adult patients and 229 births, or 660 patients, were handled for a total of 4,206 hospital days

"In my opinion, citizens of Madison County can secure the benefits that modern science offers in the prevention and cure of disease and the rehabilitation of disabilities only through a close operating alliance between a modern, competently staffed and directed full-time department of health, the practicing physician, diagnostic laboratory, and the general hospitals," said Dr John J Bourke, executive director of the New York State Joint Hospital Survey and Planning Commission, principal speaker at the Hamilton Community Forum on February 5

Dr Bourke led a panel of speakers in a discussion of the topic, "Does Madison County Need a Public

Health Department?" The panel, chairmanned by Mr Earle D Armstrong, Hamilton druggist, consisted of Dr Evelyn Rogers, district Health Officer, Dr William Liddle, chairman of the Public Health Department of the Madison County Board of Supervisors, Dr Richard Cuthbert, president of the Madison County Medical Society, and the Rev Samuel F Burhans, rector of St Thomas Episcopal Church in Hamilton

A symposium on bronchial lesion was held at Mount Sinai Hospital, New York City, on April 5 Speakers were Drs George J Ginandes, Louis E Siltzbach, Arthur H Aufses, Herman Hennell, Frederick Bridge, and Coleman B Rabin.

The first patients to occupy Millard Fillmore Hospital's newly finished pediatrics, gynecology, and surgical sections in Buffalo, were admitted in February

The pediatrics and gynecology wings are on the seventh floor of the hospital's 10-story addition, and surgical patients will occupy the

eighth

The hospital has had no pediatrics section for many years

Children who went there for treatment occupied beds in the adult sections the increased demand for pediatric care—the hospital had 600 child patients last year-it was de-

cided to install a regular pediatrics section

 Case presentations by Dr Leo Braun on "Osteochondritis Dissecans of the Knee," with discussion by Dr A. L Levy, by Dr Samuel Shenkman on "Jacksoman Epilepsy," with discussion by Dr Abraham Kaplan, and by Dr Abner I Weisman on "Maternal Hydrops with Complications—Fetal Hydrops," with discussion by Dr David Greenberg, were given at the meeting of the Clinical Society of the Jewish Memorial Hospital, New York City, on Aprıl 6

PERSONALITIES

Appointed

To the outpatient department of Staten Island Hospital, Drs Charles Accettola, Royal Howard, Michael Rapp, Francis Romano, and Herbert Schoen Dr Morris Schnittman as adjunct attending surgeon in urology at Staten Island Hospital, Dr Michael Rapp as adjunct attending surgeon in obstetrics and gynecology, and Drs Sydney Lang, Charles Accettola, and Jesse Vogel as adjunct attending physicians in medicine Dr Ernest E Kent, with the Emergency Service for Civilians in England for 1941 to 1946, as resident physician at the Dobbs Farry Hospital Dr for Civilians in England for 1941 to 1940, as resident physician at the Dobbs Ferry Hospital Dr Robert S Cunningham, dean and professor of histology at Albany Medical College, as a member of the board of managers of Ellis Hospital, Schenectady, succeeding Dr Charles G McMullen, Troy-Schenectady Road, who resigned because of ill health Dr William E Garlick, attending physician at Vassar Hospital Poughleepsie as pressured to the property of the sician at Vassar Hospital, Poughkeepsie, as president of the medical staff Dr Bernard J Mulcahy as clinical assistant in the eye, ear, nose, and

throat department at Vassar Hospital, and Dr Howard Townsend as attending physician at the hospital As physician-in-chief of the Albany Hospital and professor of medicine and director of the department of medicine at Albany Medical College, Dr Richard Townsend Beebe, Loudonville, who has been connected with the Hospital and College since 1932

Elected

As president of the medical and surgical staff of Cohoes Hospital, Dr Francis M Noonan As vice-president of the Cohoes Hospital staff, Dr J H Mitchell, III, and as secretary-treasurer, Dr M. J Keough.

Honored

Dr Charles H Richards, Dunkirk, Dr Walter H Vosburg, Dunkirk, and Dr Albert F Soch, Fredonia, by the medical staff of Brooks Memorial

[Continued on page 952]

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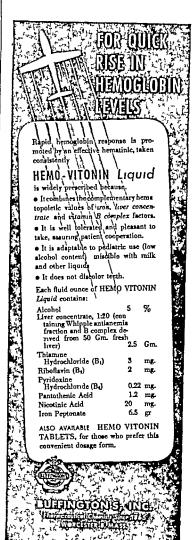
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WOMAN'S AUXILIARY

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Spring Issue of Distaff Published

A GREETING from Mrs Eustace A. Allen, national president of the Woman's Auxiliary to the American Medical Association, is a feature of the Spring issue of The Distaff, official publication of the Woman's Auxiliary to the Medical Society of the State of New York A letter from Dr Fenwick Beekman, chairman of the Auxiliary Advisory Council, is also featured, congratulating the members on their activities and service

Almost three pages of news from the county

auxiliaries is included in the eight-page publication, as well as feature stories on the program for the convention in New York City in May, on Mrs Edgar M Neptune, incoming president, "Beaux and Belles of 1965," illustrations, including a picture of the Schoharie County Auxiliary, and other items

Staff for *The Distaff* includes Mrs Lee R. Sanborn, editor, Mrs Alfred L Madden, associate editor, Mrs Arthur F Holding, business manager, and Mrs Thomas M D'Angelo, circulation manager

County News

Chenango County

Bylaws for the Chenango County Auxiliary were read and accepted at the March 9 meeting, and additional officers and committee chairmen were elected These include Mrs L T Kinney, treasurer, Mrs A. K Benedict, legislative chairman, Mrs T F Manley, public relations, Mrs H L Wilson, program, Mrs J A Hollis, publicity, Mrs M H Jacobi, delegate to the convention, and Mrs Hollis, alternate delegate

The next meeting will be held April 15 at the Sher-

burne Inn, Sherburne

Clinton County

Committee chairmen for the Clinton County Auxiliary have been appointed by Mrs Edwin W Sartwell, Peru, president of the group. They include Mrs Andrew Speare, Chazy, legislative, Mrs J J Reardon, Plattsburg, publicity and public relations, Mrs George Allen, Champlain, membership, Mrs L H Caswell, Dannemora, Hygeia, Mrs Elmer Wessell, Plattsburg, hospitality and entertainment, and Mrs Ira Rowlson, Plattsburg, program

A constitution and bylaws drawn up by a committee headed by Mrs Louella North has been adopted by the Auxiliary, which will meet four times a year, the Fall meeting coinciding with the annual meeting of the Clinton County Medical Society

Dutchess County

At the February meeting of the Dutchess County Auxiliary, held at the Vassar Brothers Hospital, Poughkeepsie, Dr Earle W Voorhees spoke on "The Eye Bank." Dr Maxwell Gosse spoke on legislation at the March meeting

Erie County

With Mrs Arthur L Bennett presiding, the February luncheon and business meeting of the Erie County Auxiliary was held in Buffalo Speaker was Mr Moir P Tanner, superintendent of the Buffalo Children's Hospital, whose subject was "Pioneering for America's Children"

The annual spring dance of the Auxiliary was held April 10 at the Hotel Statler, Buffalo, for the benefit of the Auxiliary's fund for nurse scholarships Mrs Ralph Upson was general chairman, and Mrs Thurber LeWin, cochairman Assisting were Mrs John J Elliott Mrs E Dean Babbage, Mrs George F Marquis, Mrs Joseph D Godfrey, Mrs Kenneth H Eckhert, Mrs Fred G Carl, Mrs Joseph A Zavisca, and Mrs John Edward Cryst

Nassau County

To finance a four-year nursing scholarship which they are sponsoring, members of the Nassau County Auxiliary will hold a benefit bridge on April 21 in the Garden City Hotel, according to plans announced at the January meeting by Mrs Louis H Bauer, cochairman The nursing scholarship will begin in September

Mrs E Freeman Miller is auxiliary president

Queens County

The fifteenth anniversary tea of the Queens County Auxiliary was held March 16 at the Medical Building, Forest Hills, with Mrs Adrian Donnelly, Flushing, membership chairman, in charge New members were inducted at the tea

Mrs Ezra Wolff, entertainment chairman, has announced plans for an amateur night, to be given in April by members of the Auxiliary and the Medical Society A dinner-dance is being planned for

May 15

At the January meeting, Mrs William Lavelle, Long Island City, was elected as delegate to the national convention in Atlantic City in 1949

national convention in Atlantic City in 1949

Mrs Edith B Hunter, interior decorator for a
New York City firm, was guest speaker at the February meeting, showing a complete house with wallpaper and fabrics

Mrs Daniel Swan, Flushing, is president of the group

Rensselaer County

The Marc, a four-page mimeographed bulletin containing news of the Rensselaer County Auxiliary, made its first appearance in February, with Mrs John J Noonan, Jr, and Mrs Samuel J Werlin as editors

Mrs William Oliver of the Visiting Nurse Association was guest speaker at the February meeting, held at the Troy Club Her topic was "The Visiting Nurse in Our Community"

[Continued on page 952]

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If you do not now have a confirmed hotel reservation in New York City for the Annual Meeting of the Medical Society of the State of New York, May 16 to 21, 1948, at the Hotel Pennsylvania, please fill out and mail the reservation form at the bottom of this page, and send it directly to the Hotel Pennsylvania

Should your reservation be received after the six hundred rooms set aside for the Society at the Hotel Pennsylvania have been assigned, your reservation will be turned over to one of the neighboring hotels—the Hotel New Yorker, the Governor Clinton Hotel, the Hotel McAlpin, the Hotel Martinique Please indicate your preference on the reservation blank Confirmation of your reservation will come to you direct from the hotel making the accommodation

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Please reserve accommodations as checked (/) below			
Name Address City (Unless requested otherwise, we will hold y your arrival)	State our reservati	on until 9 i	PM of the	day of
Date arriving		Hour	А.М Р М	
Room and Bath for one—per day			\$ 6	00
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	4 50	5 5	0 7	00
Double-Bed Room with Bath for two—per da	ay		8	00[
	6 00□	7 0		50□
	6 50	75	0 9	00
Twin-Bed Room with Bath for two-per day		8 0	0 10	00[
	7 00] 85	0 11	00
	7 50	9 0	0□ 12	00 🗌
Suite-Living Room, Bed Room, and Bath		 	14	50
		13 5	0 16	50□
More Than Two Persons in One Room Twin-Bed Room, the extra charge is \$2 00 per	For each add r day	litional per	son in Doub	ole- or
If a room at the rate requested is unavaila available rate	able reservation	on will be i	nade at the	next
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[Continued from page 950]

On March 17, a card party was held at the YWCA in Troy, for which Mrs JJ Quinlan was chairman, and Mrs Leo Weinstein, cochairman

Delegates to the convention in May at the Hotel Pennsylvania, New York City, are Mrs Quinlan, Mrs Weinstein, and Mrs Paul M De Luca, with Mrs J J Curley, Mrs W J Phelan, and Mrs J P Lasko as alternates

Richmond County

Mr George Farrell, director of the Bureau of Medical Care Insurance of the State Society, was guest speaker at the March meeting of the Richmond County Auxiliary, discussing various types of health insurance. The program was arranged by Mrs Michael R. Mazzei, public relations chairman. In April, a benefit bridge for the Physicians'

Home was given The annual meeting and election

of officers will be held in June

Suffolk County

A profit of over \$500 was realized from the nursing scholarship benefit dance, sponsored by the Suffolk County Auxiliary on January 3, with Mrs Benjamin Feuerstein as chairman

A nursing scholarship committee was appointed with Mrs Kenneth A Koerber, Brookhaven National Laboratory, as chairman Serving on the committee are Mrs Grover Silliman, Sayville, Mrs Edwin P Kolb, Holtsville, and Mrs Milton

Bergmann, West Islip
For the benefit of the welfare fund, a bridge party is being planned for May 7 in Patchogue Edwin P Kolb is general chairman

Tompkins County

Election of officers featured the annual meeting of the Tompkins County Auxiliary held March 15 at the home of Mrs L P Larkin, Ithaca Reports of all officers and committee chairmen were made

Officers elected were Mrs Herbert Ensworth, esident, Mrs John Hershfeld, vice-president, president, Mrs S B Kingslev, secretary, Mrs A F Nelson, treasurer, Mrs W R Short, delegate, and Mrs Norman Moore, alternate

A party was held in celebration of the Auxiliary's

first birthday

Hospital News

[Continued from page 948]

Hospital, Dunkirk, for long service in the practice of medicine and surgery and outstanding contribu-tions to community health Dr Richards has passed the 55-year mark as an active practitioner Dr Vosburg, in his second term as a Chautauqua County coroner, and Dr Soch, Pomfret town health officer, both have a 50-year professional background

Retired

Dr George W Kosmak, New York City, has retired as medical director of the Booth Memorial Hospital, after serving for eight years in this capacity and as consulting obstetrician since 1920 The Salvation Army awarded him a certificate of appreciation for his long service to their institution

NERVES TO HIP JOINT CUT TO RELIEVE ARTHRITIC PAIN

Relief from pain caused by chronic arthritis of the hip is possible for aged patients who are not strong enough to undergo regular surgery, doctors were told at the Chicago meeting of the American Academy of Orthopedic Surgeons

This merciful measure results from cutting the major nerves to the hip joint, explained Dr Benjamin E Obletz of Buffalo, New York

The operation can be done on patients of any age, for it involves a rather simple procedure, does not produce shock, and enables the patient to walk the next day and leave the hospital in one week Forty-two patients, on the average over 60 years old, have received this new surgical treatment since

May of 1946, and of these 28 have obtained some degree of relief from pain, Dr Obletz stated

While in 14 no beneficial results were noted, there were no complications or ill effects in any of these patients

This new type of operation was first reported by a Dr Tavernier of Lyons, France

–Science News Letter, February 14, 1948





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If you do not use the reservation form below, be sure to identify yourself as a physician when writing regarding reservations. This will insure proper attention to your request

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Mr James H McCabe, Manager Hotel Pennsylvania New York 1, New York			***************************************
Dear Mr McCabe			
Please reserve accommodations as checked (\checkmark)	below		
Name Address City (Unless requested otherwise, we will hold you your arrival)	State ir reservation	until 9 PM o	f the day of
Date arriving		Hour	A.M P M
Room and Bath for one—per day			\$ 6 00□
•	\$ 4 00□	\$ 5 00	6 50
	4 50□	5 50	7 00
Double-Bed Room with Bath for two-per day			8 00 🗀
	6 00□	7 00	8 50
	6 50□	7 50	9 00 🗆
Twin-Bed Room with Bath for two—per day		8 00	10 00
	7 00	8 50	11 00
	7 50□	9 00	12 00□
Suite—Living Room, Bed Room, and Bath			14 50
		13 50□	16 50
More Than Two Persons in One Room F Twin-Bed Room, the extra charge is \$2 00 per d	or each addita	onal person in	Double- or
If a room at the rate requested is unavailable available rate	e reservation	will be made	at the next
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LET'S TAKE INVENTORY

Each year at this time most business concerns close down to take annual inventory. Medicine is an art, a science—not a business. However, medi-cine can take a cue from business and apply it well Medicine cannot "close down" because it is a con-

tinuous human service, but perhaps medical societies can spare a little time and take inventory Business inventories are usually confined to making a count of goods on hand. Business liabilities are determined by totalling bills that are due and pavable. The balance, if any of the value of stock on hand plus accounts receivable minus bills payable reflects net

A medical society inventory is much more difficult to accomplish. At the same time such an inventory might be all the more important The net worth of an unregimented medical profession is beyond hu man appreciation. We learn this fact from the dis-tressed people in other countries who did not realize tressed people in other countries who did not reastise the value of an unregimented medical profession until that great intangible asset was lost as the result of nationalization of industries and professions. Of necessity any inventory along this line must be local rather than national. This in a large measure is due to varying local conditions local needs local customs and individuals that make up each Ameri can community

It may well be that the executives and officers of

local medical organisations may wish to take in-ventory—News Letter, Council on Medical Service A.M.A., January 31 1948



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the New York State Journal of MEDICINE will appreciate your following the suggestions listed below in the preparation of your manuscripts Since the Annual Meeting papers are submitted to the JOURNAL for publication, your cooperation in heeding these suggestions will save correspondence, avoid the return of scientific papers for revisions, minimize the work of preparation for the printer, and save the high costs of corrections made on the galley proofs

Size of Articles -It is earnestly desired that scientific articles shall not exceed 6 JOURNAL pages at the outside Longer articles tend to lower reader interest An average of five or six seems to be the most desirable from this point of view Calculation can readily be made by multiplying the number of double-spaced typewritten manuscript pages by the fraction two-fifths, e g, twelve manuscript pages will make five Journal pages

Manuscripts —Papers must be typewritten on one side only of white sheets consecutively numbered, and be double spaced with one-inch margins They should be prepared with great care so as to be typographically correct All headings, titles, subtitles, and subheadings should be typed flush with the left-hand margin. This is imperative for rapid the left-hand margin This is imperative and accurate composition by the printers

Titles —The title should be brief and typed in capital letters. The subtitle can be longer and should be typed in caps and lower case letters. Under the title, or subtitle, if there is one, should appear the name of the author and city in which he lives Directly under his name should be the hospital or institution with which he is affiliated

Subheadings —Subheadings should be inserted by the author at appropriate intervals

References—It is the unfailing practice of the New York State Journal of Medicine to use specific "references" rather than "bibliography" There should appear in the text reference numbers, typed above and to the right of the word to which there is a reference A list, consecutively numbered, of these references should follow at the end of the cript (Note that spelling in list is same as in The arrangement should be as follows and manuscript should include all items

Books—author's surname followed by initials, title of book, edition, location and name of publisher, year of publication, volume, and page number Thus, Osler, W Modern Medicine, 3rd ed, Philadelphia, Lea & Febiger, 1927, vol 5, p 57

Periodicals—author's surname followed by nitials, name of periodical, volume, page, month (day if necessary), year of publication Thus, Leahy, Leon J New York State J Med 40 347 (March 1) 1940

The JOURNAL does not include titles of articles

Case Reports -Instead of abstracts of hospital histories, authors should write these reports in a narrative style with properly completed sentences All unimportant details should be deleted with such general negative statements as fit the case

Tables —While tables are very useful on lantern slides in the reading of papers, they fail of this pur-pose to a large extent in the printed page For that reason it is urged that they be reduced as much as possible to descriptive language

Illustrations -These should be kept to the minimum necessary to make clear the points to be registered by the author. In some instances they are imperative to proper understanding, in others they are merely picturesque. The latter can be excluded to good effect, both as to space and the not inconsiderable cost

When illustrations are to be used they should accompany manuscripts and each should always be referred to in the text, preferably by number Drawings or graphs should not be larger than 12 × Drawings or graphs should not be larger than 12 X 16 inches, and must be made with jet black India ink on white paper Do not use typewriter for lettering The smallest lettering on 8 X 10 inch copy should be no less than 1/4 inch high Cross-section paper (white with black lines) may be used, but should not have more than 4 lines per inch. If finer ruled paper is used, the major division lines should be drawn in with black ink, omitting the finer divisions. In the case of finely ruled paper, only In the case of finely ruled paper, only blue-lined paper can be accepted Lettering and all markings must be large enough to be readable after reduction Mail rolled or flat, never fold Photographs should be very distinct and show clear black and white contrasts They must be on glossy

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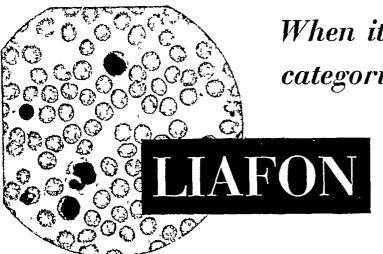
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Allegany		H. G Chamberlin Cuba	L P Bly Cuba	
Bronx		G B Gilmore Bronx	C W Frank Brony	
Broome		R. S McKeeby Binghamton	J W Kane Binghamton	
Cattaraugus	J S Fleming Salamanca	TIT D A Al	Q Q QL	
Cayuga	C T Yarıngton Moravia	J D Hammond Auburn	L H Rothschild Auburn	
Chautauqua	E O Black Fredoma	Edgar Bieber – Dunkirk	C E Hallenbeck Dunkirk	
Chemung	A. C. Glover Elmira	H A Burch Elmira	E S Ridall Elmira	
Chenango	J A Hollis Norwich	J H Stewart Norwich	J H. Stewart Norwich	
Clinton	W W Johnson Plattsburg	K. M Clough Plattsburg	K. M Clough Plattsburg	
Columbia	L D Carpenter Germantown	L J Early Hudson	L J Early Hudson	
Cortland	R. H. Kerr Cortland	E F Higgins Cortland	F F Sornberger Cortland	
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Oswego	J L H Mason Pulaski	U Cimildoro Oswego	U Cimildoro Oswego	
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PART I NUTRITION*

9:30 A M

1 Some Newer Aspects of Protein Utiliza-

David Schwimmer, M. D., Associate Visiting Physician, Metropolitan Hospital, Associate in Research, New York Medical College, Flower and Fifth Avenue Hospitals, New York Thomas H. McGavack, M. D., Professor of Chinical Medicine, New York Medical College, Flower and Fifth Avenue Hospitals, New York

2 The Influence of Disease on Nutritional Requirements

Herbert Pollack, M.D., Associate Physician and Chief of Metabolic Division, Mt. Sinai Hospital, New York

John Bookman, M.D., Assistant Resident for Metabolic Diseases, Mt. Sinai Hospital, New York

PART II REHABILITATION and PHYSICAL MEDICINE*

Dynamic Therapeutics in Chronic Disease, with a Clinical Demonstration Howard A Rusk, MD, Professor of Rehabilitation and Physical Medicine, New York University College of Medicine, Associate Editor, New York Times, New York

PART III PANEL DISCUSSION: MODERN TRENDS IN MEDICAL CARE 2:00 P M

Louis H Bauer, M D , Presiding, President,

PART IV ROUND TABLE CONFERENCE ON MEDICAL CARE INSURANCE IN NEW YORK STATE

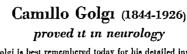
A H Aaron, MD, Buffalo, Presiding, Chairman, Subcommittee on Medical Expense Insurance of the Council Committee on Economics

- Benefits Offered by Voluntary Nonprofit Medical Care Insurance Plans in New York State Carlton E Wertz, M D, President, Western New York Plan, Inc., Buffalo
- Advantages of a Service Contract for Low Income Subscribers Milton J Goodfriend, M D, Board of Directors, United Medical Service New York
- 3 Progress Report on Voluntary Nonprofit Medical Care Insurance Plans in New York State George P Farrell, Director, Bureau of Medical Care Insurance, Medical Society of the State of New York
- 4 Home-Town Medical Care of Veterans under Veterans Medical Service Plan of New York, Inc.
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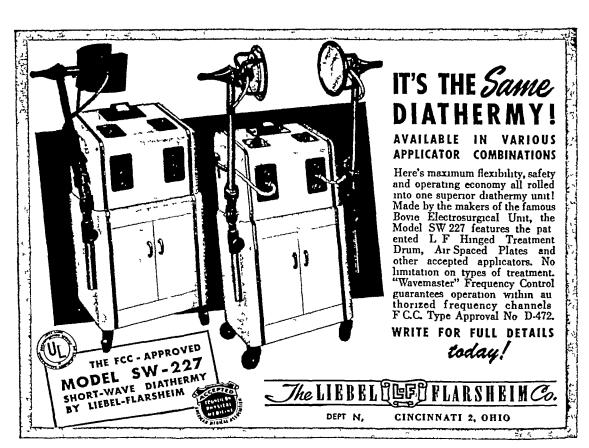
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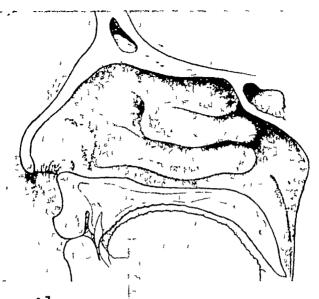
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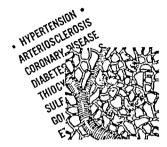
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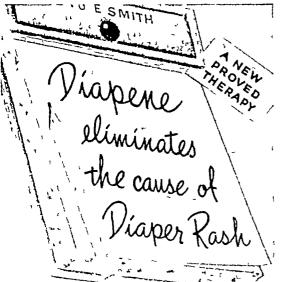
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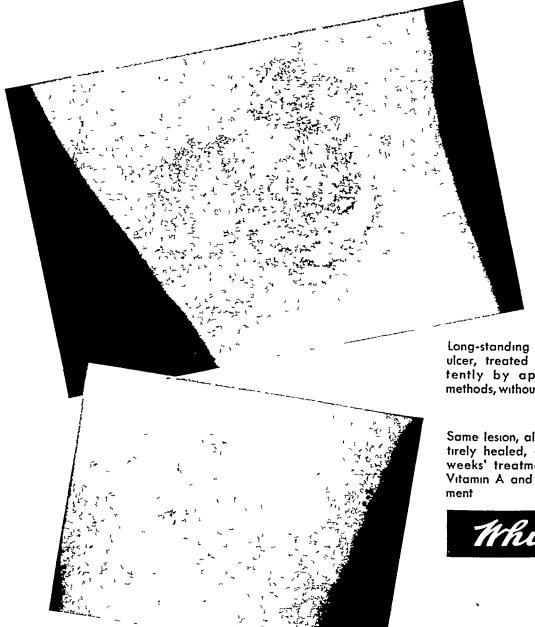
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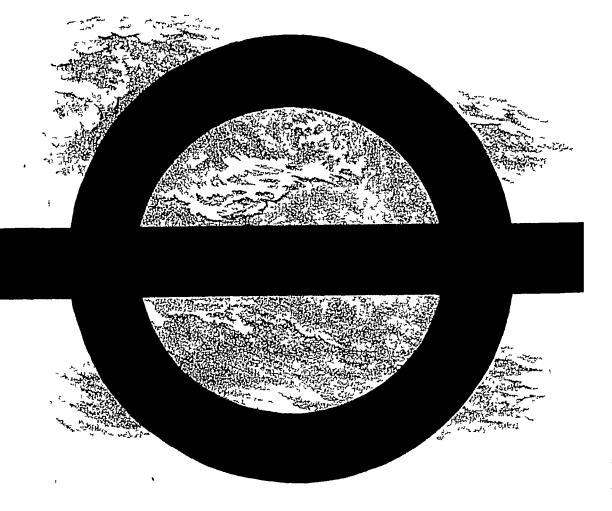
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Quickly applied
Relieves pain

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and sleep without symptoms or with helpful relief thanks to Abbott's new antihistaminic, THEMYLEND Hydrochloride, \ majority of these patients will notice few nde-effects under treatment with THENYLENE

In a total of 695 cases reported by different investi gators, Thenylene Hydrochloride averaged 67 per cent effective for the entire group. The reports covered a wide range of conditions allergic rhinits of the sea sonal and perennial types vissomotor rhinitis acute and chronic urticaria atopic dermatitis including reactions to penicillin and other drugs and some cases of asthma. The patients subjective evaluation of different antihistaminics was also reported. In one test group, a significant number of patients expressed a preference for THENYLLNE-a preference based largely on the lower incidence of side-effects.

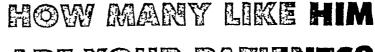
An Initial dose of 100 mg, three or four times daily is suggested to alleviate severe symptoms. As a main tenance dose or for less severe symptoms 50 mg ses eral times daily may be adequate. While no harmful effects have been reported, a total daily dose exceed ing 400 mg (0.4 Gm) is not recommended nor continuous administration beyond eight weeks until more is known about the drug

Try this new antihistaminic on your next ten cases. Your pharmacist has THENVLENE Hydrochloride in sugar coated tablets of three sizes, 25 mg 50 mg and 0 I Gm. (100 mg) in bottles of 100 and 500 tablets. ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS.

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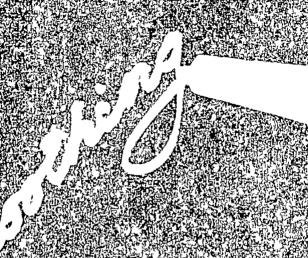
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in weight reduction new evidence of the efficacy of Dexedrine

Excerpts from a recent study entitled, THE MECHANISM OF AMPHETAMINE-INDUCED LOSS OF WEIGHT A Consideration of the Theory of Hunger and Appetite—by Harris, S. C., Ivy, A. C., and Searle, L. M. J. A. M. A. 134 1468 (Aug. 23) 1947

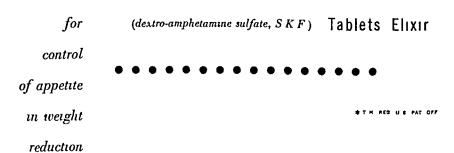
experiment 1 Does 'Dexedrine' Sulfate, by controlling appetite, decrease food intake and body weight in human subjects?

results " our obese subjects lost weight when placed on a diet which allowed them to eat all they wanted three times a day . . ."

experiment 4 Does the rather prolonged administration of Devedrine cause any evidence of disturbance of tissue functions?

results "No evidence of toxicity of the drug as employed in these studies was found no evidence of deleterious effects of the drug was observed"

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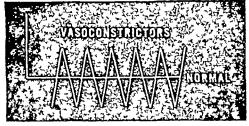
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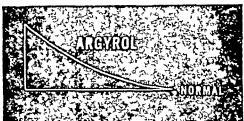
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Rhinitis Medicamentosa—a result of repeated rebound congestion-is attributed solely to the use of vasoconstrictors Use of ARGYROL accomplishes the main

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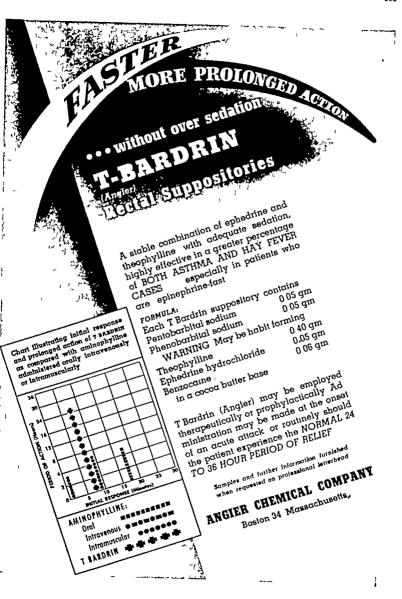
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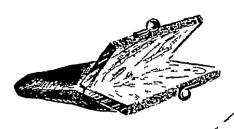
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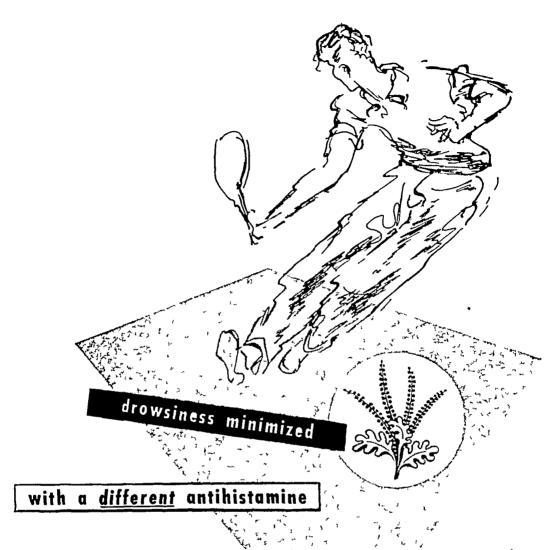
Gerilac, specifically designed for the aged, is a fortified powder of spray-dried whole milk and skim milk, within the financial reach of all At a cost of only 19c a day, one reliquefied pint of Gerilac provides 1/3 of the proteins, a full allowance of each of the necessary vitamins* and minerals, and 300 calories in two 8-ounce glasses of tasty drink. And remember, Gerilac is economical because it doesn't have to be mixed with milk.

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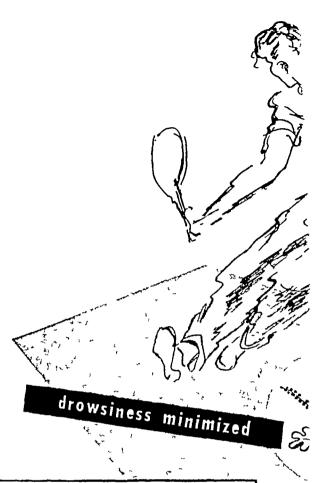


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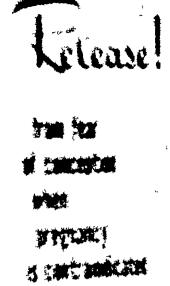
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As a new and completely different antihi offers significant advantages, in the treatme contrast with other antihistamine drugs, Their ness, in fact, it has a mildly stimulating effect perience covering more than 2000 cases c is not only highly effective but characterized reactions. Available in oral tablets, 25 per teaspoonful (4 cc) Write to Dept T-6

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THEPHOR

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Isoleucine	80
Leucine*	106
Lysine* Methiomne*	8.2
Methionine*	30
Phenylalanine	51
Threonine*	44
DL-Tryptophane Valine	10
Valine*	8 1
Other amino acids	

Total Nitrogent a Amino Ntj s a Amino N of	13
Amino N‡†	10
% a Amino N of	
Total N.t	75

(approx) 42% by difference

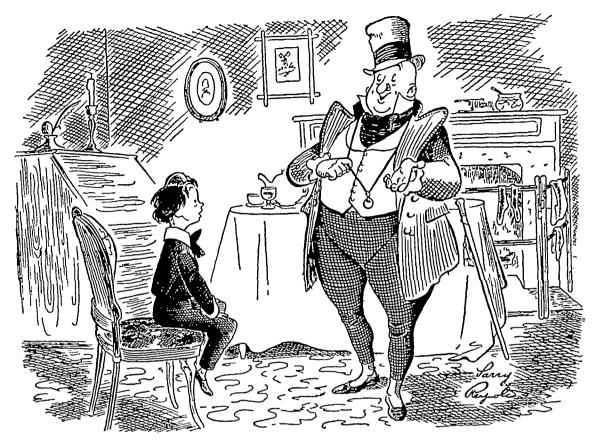
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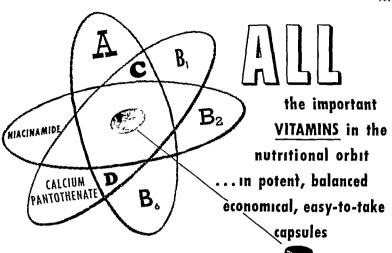
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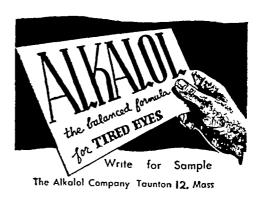
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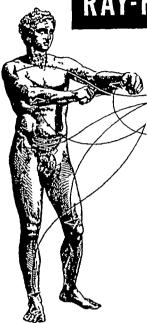
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Page 1087







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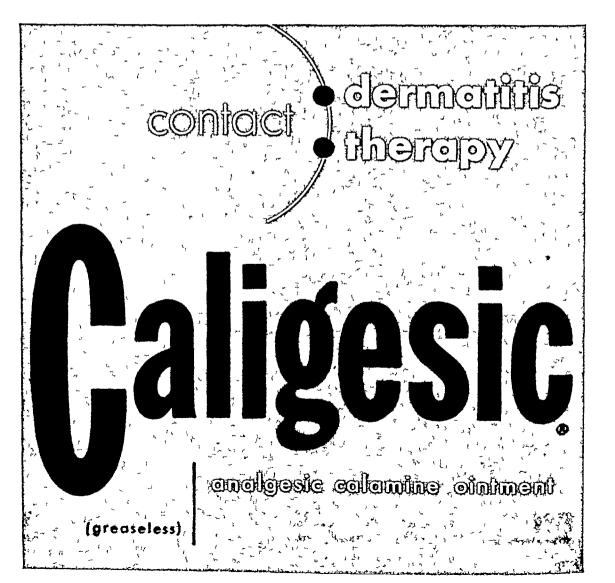
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VOLUME 48

MAY 1 1948

NUMBER 9

Editorials

The Eyeglass Racket

Repeatedly the American Medical Association, and many state and county medical societies, have called attention to the un ethical practices of those physicians who receive rebates. In the State of New York in 1944, the Moreland Act Commission found extensive abuses in Workmen's Compensation practice by physicians who received rebates from commercial and professional sources. In this State the Workmen's Compensation Law was amended, as was also the Education Law, in 1944, imposing severe penalties on those found guilty of unfair, unethical, or illegal acts.

In July, 1916, antitrust complaints were filed by the Department of Justice against two major optical manufacturing companies and many physicians. This followed previous criminal suits in 1940 against two principal optical manufacturing companies and four other lesser manufacturers on grounds

of price fixing

The net result of the rebating and the price fixing agreements has been to maintain the retail prices of optical necessities at an artificially high level said to have cost the public some \$35,000,000 a year "above and beyond the real price of their glasses and in addition to the fees they paid their physicians".

and in New England "eyeglass users have been relatively free of the rebate plan."¹ This does not mean that in those areas con sumers have not been subjected to the artificially maintained prices, they have been, and probably are still, because of trade practices. In other areas of the country where rebat-

Note that in the Middle Atlantic states

In other areas of the country where rebating has been practiced, something is being done about it. As an example, the Better Business Bureau of Los Angeles, Ltd, has initiated a campaign of continuing publicity that should be effective in eradicating a great many of the abuses. In an open letter to the Council of the Los Angeles County Medical Association, the Better Business Bureau states, in part

The problem has received intermittent attention by our office and your Association during the past seven years. However as far as we know, the Council has failed to meet the issue "head on" and has adopted no program specifically designed to curb this unfair and unethical practice. That is the reason we deem it necessary to proceed with a program of our own at this time.

Literally hundreds of your members are receiving secret medical rebates or employing devices of one kind or another, which from the patient's point of view, are tantamount to the same thing. The doctors referred to, in the interest of personal gain to themselves, channel

^{1 "}Better Vision with a Kickbook," Maisel, Albert Q.: Reader's Digest (Jan.) 1948, p. 26

their patients' prescription business to certain firms which reward the doctors for doing so

The four devices or schemes currently used are referral rebates, agency appointments, co-op cash and credits, rent ruses

Referral rebates are paid to doctors by a number of x-ray and clinical laboratories, by dispensing opticians, by pharmacists, and others. The practice of such firms is to charge the patient about double the amount the firm wishes to retain and remit the 100 per cent overcharge to the doctor. Some of these firms publish price lists of their services and solicit business by informing doctors that half of the moneys they collect from the doctor's patients will be "kicked back" to him

Agency appointments have recently come into vogue because this arrangement permits the doctor technically to deny that he accepts rebates The arrangement is simple contract, the doctor appoints a dispensing optician to act as his agent in the filling of prescriptions and in selling eyeglasses The doctor sends his patients to his agent, the optical com-Technically, the doctor himself then makes the sale at prices he himself has established, although the patient—since he seems to be dealing with a third party—doesn't realize this Actually, the dispensing optician handles everything just as though he were doing the business strictly for his own account, except that the patient is sometimes given the doctor's receipt In the operation of this device the patient is usually charged approximately 100 per cent more than the amount retained by the dispensing optician for his services in filling the prescription and furnishing the glasses The full amount received from the patient is credited to the doctor's account, and his account is charged with about half of this amount for the dispensing optician's services

The co-op cash and credit plan is one which has been in use for many years From available evidence it appears that hundreds of doctors employ this device Each doctor has an investment of \$25 in a co-op laboratory in the form of an associate membership The co-op is controlled and operated by several people actively engaged in its management. They fix their own salaries, bonuses, etc The doctors holding associate memberships send their patients to the laboratory for x-ray and clinical laboratory work The laboratory has two price lists, the first is a so-called "cost" price and the second is the "patient's" price The latter is approximately 100 per cent higher than the "cost" to the doctor The difference represents the doctor's "profit" from referring the business of his patients to "his" laboratory

The rental ruse is the latest device employed for paying doctors for referring their business to dispensing opticians. It is a scheme whereby the dispensing optician "rents" the doctor's office one afternoon a week. After examining the patient, the doctor tells him to return on a certain afternoon when a man will be there with eyeglasses so that the patient can select the style he desires. The optical company representative uses the doctor's office at the appointed time, sells the glasses for his firm's account, his charges are, of course, sufficiently padded to enable him to pay the "rent" to the doctor.

The Better Business Bureau of Los Angeles proposes to maintain a continuous campaign of publicity by

Mailing a copy of this letter to all doctors in this [Los Angeles] County, with a request for their pledges to accept no rebates, publicity regarding this action, publicity regarding replies received, letter to all clinical and x-ray laboratories, dispensing opticians and others, requesting that they pledge to give no rebates or participate in any of the devices outlined, publicity regarding this request, publicity regarding the response, placing attached poster "Does Your Doctor Get a Kickback from Xray and Clinical Laboratories?" on 2,800 employe bulletin boards, publicity regarding issuance of poster, news story regarding hospital rules re rebates, issuance of general letter to business firms, members of P-T.A, etc, listing x-ray and clinical laboratories, dispensing optitians and other who have pledged to give no rebates, news release containing Attorney General's opinion relative to legality of rebates, distribution of two-color poster 'Does Your Oculist Get a Kickback?", news release re poster, distribution of printed bulletin picturing rebating laboratories, their price lists, etc, to members of P-TA, women's clubs, social agencies, others-50,000 by mail, 40,000 bulk, news release re bulletin, follow-up letter to all doctors re rebate pledges, creation of pledge list and news release regarding it, continuous investigation starting at once to develop evidence for submittal to legislative bodies, if that seems necessary at a future date

We present this tentative plan of action to acquaint our members with the steps which are contemplated elsewhere to initiate a joint campaign by business interests and the medical profession to correct and eradicate, with the assistance of the government, such unethical practices where they exist

Housecleaning Time

The Veterans Administration is to be congratulated upon the appointment of Dr Paul Magnuson as medical director, replacing Dr Paul R Hawley, resigned We feel confident that the truly noteworthy accomplishments of the former director in the provision of excellent medical service for veterans will be maintained by his successor and expanded if such expansion scems warranted by the facts Good medi cal service made available to veterans, early and with as little obstruction by red tape as possible, will reduce later suffering and increased costs from neglected disease requiring early and adequate medical care

This was the goal attempted by the hometown medical care plan Report forms for authorized service-connected cases were simplified, and delays in payment for treatments were kept to a minimum. In the State of New York, for a while, the program operated by the Medical Society and the V.A seemed to be going well. In the nature of things, some misunderstandings and difficulties might have been anticipated, and such in fact there were, but these were strughtened out by conference and compromise

However, in mid-1947 appropriations were cut by Congress, necessitating retrenchment by the V.A. Inevitably this resulted in restriction of authorizations for the hometown medical care programs, and just as inevitably increased the number of cases shifted to V.A. clinics.

The New York Times' reported under a Washington dateline, and we reprint in part

A crackdown on doctors suspected of "chiseling" in the care of alling war veterans was announced today by the Veterans Administration.

Dr Paul Magnuson, medical director for the agency told a news conference that he was preparing a list of suspected physicians for presentation to the American Medical Association.

Dr Magnuson said that the list was not a

long one because "there are very few real chiselers in our profession."

He asserted that those physicians found guilty of overcharging the government for treating reterans, continuing treatment beyond the need, running patients through rapidly without proper care, and in other ways attempting to increase veterans' medical bills, would be barred from practice

Dr Magnuson said that all the physicians on his list had been engaged on a fee basis under agreements offering hometown care to veterans. Most physicians are empowered under blanket contracts with state medical someties to offer such treatment, he added, and here and there abuses have been reported.

And in Chicago,

Dr George F Lull, secretary and general manager of the A M.A., asserted that, if Dr Magnuson aubmitted a list of physicians suspected of "chisoling" in the treatment of war veterans, the names would be turned over to state medical societies for disciplinary action.

"The American Medical Association is a fed eration of component state sometics, and it will be up to these medical sometics" he said, adding that machinery for "disciplining members exists within the state sometics and not within the A M.A.—the parent body"

Dr Magnuson quite properly commences his administrative duties, with the assistance of the A.M A., in cleaning house

We regret the restriction of the veterans' hometown medical care program. We are reluctant to believe that such few cases of "chiseling" as may be proved to have occurred could have had more than an infinitesimal influence on the total cost of a program of such magnitude

The membership of the Medical Society of the State of New York has enthusiastically and competently collaborated with the V.A. under General Bradley and Dr Hawley in the endeavor to make an excellently conceived program of hometown medical care work in the interest of the voteran, and will continue to do so under Mr Cary and Dr Magnuson—to the extent that the administration will or can authorize such care under existing contract.

¹ New York Times (Jan. 17) 1948.

Reform

Readers of the public prints, both magazines and newspapers, will have remarked in 1948 a commendable pressure for "reform" In medicine, up to the time of this writing, such pressure has been directed to the elimination of rebating¹ and the creation of greater educational opportunities for negro students 2

In the State of New York the Young Commission on the need for a State University has been studying the problem of the wider provision of educational facilities either by taking over Syracuse University or by the establishment of regional constituent colleges Studies by the Commission show that 95 per cent of high school graduates in this State who qualify for college training but fail to get it "are deprived of doing so by mability to meet the cost, and only 5 per cent fail by reason of racial or religious discrimination "2 The Commission did favor State acquisition of an upstate university, preferably Syracuse, and its operation as a State university, also the establishment of some junior colleges, more State scholarships, and State aid for the expansion of some professional schools

The Democrats on the commission were against the Syracuse plan but wanted a large new State university They also wanted two or three medical centers, with schools of medicine, dentistry, nursing, and public health They favored more scholarships and more community colleges This opposition by the Democratic members of the Legislature apparently has been met by the suggested establishment of a board of trustees of the University of the State of New York to be set up at this session of the Legislature, the board of trustees of the University to hold office for a At the conclusion of its term sıx-year period of office this temporary board should make a final report of its activities to the Board of Regents and to the Legislature and recommend a plan for further development of the University and for its continuing governance and supervision The constituent schools and colleges of the University may be separately incorporated with local boards of trustees which shall have local administrative power, but shall derive their authority in matters of education

Reader a Digest (Jan.) 1948 * Saturday Evening Post (Jan. 24) 1948 New York Times (Jan. 12) 1948 p 216

and policy from the trustees of the University The prime effort of the University should be to maintain throughout the State constituent colleges and schools, including medical and other professional teaching and research centers, which, taken in conjunction with existing facilities, will give a completely rounded and adequate university program for the State The plan is to include community colleges which shall be financed 50 per cent of the cost by the State and 50 per cent by the community in capital outlay, in maintenance and operation, one-third of the cost by the State. one-third by the community, and one-third by student fees The above program at the present time seems to satisfy both parties sufficiently so that it is probable that such legislation will be enacted this year

Bronx Hospital announces hospital affiliation for general practitioners. establishment of a general practice section in its staff 5

The president of the medical board of the hospital said general practitioners seeking appointment to the staff must be graduates of approved medical schools, members of the county medical society, and able to meet all other requirements of medical staff membership provided in the hospital's bylaws

The section will be governed by a committee including one representative from the section and the hospital's departments of medicine, surgery, and obstetrics This committee also will plan an educational program for the section

The hospital is acting to meet a need cited by the American Medical Association, the American College of Surgeons, and other leading groups, it was declared

While prepaid medical care plans for the last eight years have been cooperating with the Federal Farm Security Administration to provide medical and surgical care for rural areas of the State (the FSA. lending money to their borrowers to enroll on a plan during the first year of membership), the plan has not been too successful borrowers dropped out after the first year b Still, it is an attack on the problem AMA. survey of the medical schools in

<sup>Legislative Bulletin #1 (Jan. 19) 1948.
New York Times (Jan. 22) 1948.
Extension of Rural Medical Service, A.M A. 1947</sup>

November, 1947, showed them to be interested and active in developing programs toward extending medical care to rural communities. Several medical schools already have scholarships for physicians who will practice in rural areas, preceptorships with rural physicians for medical students in their senior year, rotating internships from university hospitals to rural hospitals, extension of medical care to rural clinics.

The Mary Imogene Bassett Hospital, in Cooperstown, New York, is now affiliated as a teaching hospital with the Columbia University College of Physicians and Surgeons in New York City. A number of fourth year students spend two months in this outstanding rural medical center to participate in rural medical practice. Similar practical extensions of teaching centers into the rural areas are not headline news but they do represent farseeing experimental projects which will vastly enrich the prac-

tice of medicine in the future, and represent

Much remains to be done. More of the slow solid accomplishment of American doctors in solving the complex problems of modern civilization should be known to the people via the popular publications and the daily journals. These have tended rather to overemphasize the importance of "wonder drugs," and some of the more radical developments of medical therapy. While the radio, around the clock, chatters the virtues of proprietary medicines, self medication and fills in the chinks with horror and crime ad nausean.

Decidedly, reform should be accomplished where it is needed. And this is not to overlook the substantial improvements in modern journalism, better and more accurate reporting, and wider news' coverage are among other things—also to be said of radio in general. Let the good work go on

Current Editorial Comment

Outlook Brighter for Heart Disease
The importance of heart disease as the most
common single cause of death in children
as well as in adults very largely because of
the great reduction in deaths from infectious diseases, has been pointed out by
Walter Modell, M. D. New York, instructor
at Cornell University Medical College and
fellow of the American College of Physicians 1 Dr. Modell also states that in
adults arteriosclerosis eventually comes to
all who hye long enough

For this reason Reart discuse will continue to increase as the average span of life is length

ened by progress in medicine

"Actually" the writer observes "our under standing of the heart has increased new useful drugs have been introduced and more are being discovered, delicate instruments for early diagnosis are available, preventive measures are being developed, surgical procedures for the repair of many types of heart disease have been devised. The weapons are available for the attack on this formidable problem

Among these weapons he mentions

I Surgery to repair congenital defects of

the heart in the small proportion of children born with defective hearts.

2 Now awareness of the rheumatic fever problem (Rheumatic fever causes the largest proportion of heart disease in youngsters and young adults and causes more deaths in that ago group than any other disease.)

3 Surgical treatment for high blood pressure a condition which eventually damages the heart through the undue effort to which

that organ is subjected in pumping

4 Increased control of syphilis and goiter which are almost disappearing as causes of heart disease

- 5 A recently discovered cure for subacuto bacterial endocarditis, an infection which at ways attaches itself to a portion of the heart damaged by previous heart disease. Until soveral years ago everyone who developed this disease died of it. Today, with huge doese of penteillin, 90 per cent or more are entirely cured. Cures may be on the way for other heart infections.
- 6 More effective treatment for the later consequences of heart disease often called heart failure. With the proper use of purified extracts of digitalis and a newer group of drugs called mercurial diuretics many victims

¹ Hygein (Jan) 1948; A M A. News (J n 30) 1948.

of advanced heart failure, formerly considered beyond treatment, are now entirely relieved of symptoms. Even though the fundamental disease condition remains severe, lives are prolonged, and made useful and pleasant, where formerly they were unbearable. Many such patients have returned to work

7 Improved methods for early diagnosis A thorough examination by the cardiologist—the heart specialist—together with modern examining technics such as the x-rays, fluoroscope and electrocardiogram and special blood tests, makes the recognition of heart disease possible in its earliest stages

"For those who are unfortunate and develop heart disease early in life, and for those who develop heart disease because of age, the outlook is better than it ever was," Dr Modell concludes

Clue to the Synthesis of Food Reported at the December annual meeting in Chicago, Illinois, of the American Association for the Advancement of Science were significant advances in the knowledge of how nature synthesizes foodstuffs According to the New York Times 1

The discovery of the new key substance, described as the first intermediary in the process of food synthesis by the plants, the very existence of which was until now not even suspected, was made possible by the use of radioactive carbon, itself a new substance produced in the atomic-energy furnace at Oak Ridge, Tennessee

Ordinary carbon dioxide, which contains ordinary carbon of Atomic Weight Twelve and is non-radioactive, goes through so many complex processes within the plant that it was impossible to trace its course through nature's labyrinth. With carbon dioxide in which radioactive carbon of Atomic Weight Fourteen is substituted for the ordinary carbon, the complex processes involved could be traced for the first time by the radioactivity of the substance

It was discovered that the plant uses the carbon dioxide for two distinct and opposite purposes, one for its own respiration, the process by which foodstuffs are utilized in living cells, the other for photosynthesis

The discovery of the key substance may open the way to two of the most significant developments in the history of civilization Further knowledge of its chemical composition and structure, studies on which are now in progress, may pave the road to the creation of synthetic foods in great abundance out of carbon dioxide and water by the use of only solar energy. It also may provide the first means for the direct harnessing of the sun's light for power purposes, thus providing mankind with an inevhaustible source of power

The report, one of the outstanding developments in science in modern times, was presented before a symposium on the use of isotopic tracers in photosynthesis by Prof Hans Gaffron, Dr A H Brown, and Dr E W Fager, of the Fels Laboratory of the University of Chicago Dr Brown is now associated with the department of botany of the University of Minnesota

Already the potentialities of radioactive tracer methods of investigation are beginning to outweigh the fearsome aspects of the same energy in the form of atomic bombs. The possibilities which this research opens up, as well as the utilization of the same methods in the study of human metabolism, will probably necessitate a fundamental revamping of our older concepts of human and plant physiology.

In their studies, the Chicago biochemists succeeded for the first time in separating the products formed in the processes of the plants' respiration from the products formed in the processes involving assimilation, namely photosynthesis. The respiration product, which also contained carbon dioxide, is active in the dark and was shown to be easily transformed by metabolic reactions pertaining to respiration and fermentation.

On the other hand, the first photosynthetic product was found to be completely stable in the dark, is not attacked by respiration, and does not lose its tracer carbon by exchange with untagged carbon dioxide

It is transformed into ordinary metabolites, such as sugars, the report adds, only by the further action of light. It is thus shown to be an intermediate in the process of sugar formation

The first supply (a few milligrams) of the new substance has been used in proving that it is none of the more common carbohydrates, nor one of the better known respiratory dark fixation products, such as, for instance, succinic acid

The research represents a new attack on the basic problem which was investigated with radioactive tracer methods by the late Dr Sam Ruben and coworkers of the University of California

¹ New York Times (Dec 29) 1947

Scientific Articles

RADIATION DOSAGE

WALTER T MURPHY, M.D., Buffalo, New York

(From the Roswell I ark Memorial Institute)

R ADIATION desage means the amount of radiant energy delivered to, but not actu ally absorbed by, an anatomic site within a specific space and periodicity of time amount is expressed by the term 'roentgen" (r) which is an ionization unit bearing a constant and known relation to the radiation energy absorbed per unit mass of air, and when applied to air, it is independent of wavelength roentgen doses are recorded as with back scatter at this institute, and in this paper all doses are with back scatter. The method of applying the tumor dose is described by the quality, site, size, reparation and angulation of entrance ports, skin target distance, portal roentgen increment, roentgen per minute, cycle or spacing of portal applications, and description of the area of source It is improper to record only the entrance dose, except in the superficial lemons where the skin or mucous membrane and the lesion itself are in the same plane.

Failures with radiation should not be blamed upon the "dose' delivered to the leason unless other treatment factors, such as quality, skin target distance, field size, and value and spacing of the increment, have been considered perfectly competent to the problem of treatment.

Radiation can almost always be cancericidal if the treatment factors mentioned above are appropriate, but they may be of such an order that the life of the patient is sacrificed adage that "the operation was a success but the patent died" is perfectly applicable to radiation therapy Therefore, the clinical picture must be thoroughly understood by the radiologist before any radiation is attempted. It is important that there be close cooperation between the referring physican or surgeon and the radiologist. The latter should examine each patient before any regime is decided upon in order to estimate the radiocurability of the lesion and the compatibility of the regime with the survival of the Should the case be judged not radiocur able, then the degree of palliation that radia tion offers should be ascertained. If neither

cure nor palliation is apparent from the clinical picture, then no radiation is indicated. Occa sionally, placebo treatments are given these patients for obvious mental reasons. Much larm is done to the practice of radiology by the treatment of patients who are beyond even palliation. Other modalities should be offered these patients.

Action of Radiation

The biologic effect of radiation is due to that part which is absorbed. The ability of a normal or cancer cell to recover from radiation is a relative one, depending upon such factors as (1) cellular activity, whether the cell is in the dividing or resting stage, and (2) the surrounding tissue bed. Both these factors are influenced by heredity, endocrines, age, and the general health status of the patient.

The primary function of radiation therapy is to destroy pathologic tissue. The specific minimum number of roentgens necessary to kill any human cancer is not accurately known, and there is not true consistency between tumor roentgen does and cure Radiosensitivity does not mean radiocurability, since the accessibility, anatomic grading, and inherent biologic behavior of a cancer are more important than the histologic grading

Clinically, the total tumor dose is important only if it is qualified by all technical details of application. Although there is no wavelength specificity, the biologic-physical-roentgen ratio between wavelengths is apparent. At 45 kilovoltage peak, the arythema dose is 200 r or less. while at 1 000 kilovoltage peak, it is 1,000 r or more. The ratio between 200 kilovoltage peak (half value layer 0.9 mm. copper) and 1,000 kilovoltage peak (half value layer 9 mm. copper) is of the order of 4.5 When cross fire causes an entrance port to receive exit radiation from another port, the problem of comparative biologic effect is slightly changed because of the altera tion in effective wavelength of a beam as it traverses and leaves an anatomic part. Figure 1 shows akin erythema on last day of treatment almost identical on the right side of the pelvis cross fired by 1,000 kilovoltage neak (half value

Presented at the 141st Annual Bleeting of the Medical Society of the State of New York, Buffalo, Scotion on Radiol ory, May 8, 1047

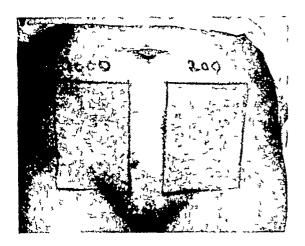


Fig. 1 Equal skin reaction on last day of treatment with same total skin roentgens (increment plus exit dose) Posterior ports show comparable reactions

layer 9 mm copper) \-ray, to that on the left side, cross fired by 200 kilovoltage peak (half value layer 0 9 mm copper) \-ray Figure 2 shows the same skin four months later with more scarring and atrophy on the 200 kilovoltage peak side. The total "r" dose on the skin was equaled for all ports by increasing the 200 kilovoltage peak increment to make up for the greater penetrating power of the 1,000 kilovoltage peak beam. Thus, the increment for the latter side was 400 r, while the increment for the former side was 435 r. The total "r" dose to each port was 4,520 r within twenty-three days.

Other studies with different skin increments have been carried out with about the same effect There have been some variations which will be reported later Of course, the depth dose on the 1,000 kilovoltage peak side was greater case illustrated it amounted to about 30 per cent more Since it takes more 1,000 kilovoltage peak roentgens as measured by a thimble ionization chamber to cause a skin erythema, it is reasonable to assume that it would take more 1,000 kilovoltage peak roentgens to effect damage on a cancer comparable to that damage caused by 200 kilovoltage peak roentgens Hence, supervoltage is of more value if the tumor roentgen dose can be greater than the 4 5 ratio This condition prevails in cross firing a thick anatomic part with multiple ports when the skin and normal tissue doses are much inferior to the tumor dose With comparable technic it might be impossible to deliver with 200 kilovoltage peak (half value layer 0.9 mm copper) y-ray such a favorable difference in roentgens (tumor dose minus normal tissue dose)

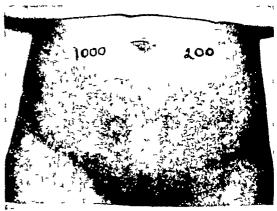


Fig 2 Skin reaction four months after treatment. More scarring and atrophy on 200 kilovoltage peak side. Posterior ports show comparable changes.

Dosage Technic

The different dosage technics, used in chinical radiation therapy, are discussed separately

Single Dose—This may be used when a cancericidal dose can be given to the deepest cell of a radiocurable lesion, e.g., basal cell carcinoma, without danger to the deeper or surrounding normal tissues. Ideal factors are as follows

- (a) Lesion diameter less than 1 cm, thickness less than 0.5 cm, and accessibility, e.g., skin of cheek
- (b) Field size—wide enough to include most laterally extended cells—Here, the experience of the radiologist is an important factor—Since the border of the field receives less than the midpoint, a margin of 0.5 to 1 cm should be included for these small lesions—Four times the dose is required to bring about the same biologic effect with an area of 0.4 sq cm as with one of 6 sq cm when qualities of half value layer 1.5 mm aluminum to 0.4 mm copper are used This is due to physical reasons and volume tissue effect.
- (c) Quality most of the radiation should be absorbed by the cancer tissue and only a minimum by the normal bed In treating a superficial and thin lesion, soft radiation is indicated (45 to 140 kilovoltage peak x-ray)

(d) Skin target distance—should be as short as is clinically and physically feasible in order to insure maximum delivery to the cancer only

Table 1 shows comparative depth percentages with the different qualities and skin target distance used in superficial therapy

In the treatment of cancer, the normal skin, mucous membrane, and subcutaneous tissue will react very intensely but will recover with some permanent damage from single applica-

TABLE 1 - COMPARATIVE DEPTH PERCENTAGES IN SUPER-

FICIAL LEMARTI						
Purcentages with Different Radiation Qualities 3 Rq Cm Area 10 Rq Cm Area 2 Cm 8 T D						
Centi- meter Depth	45 K.V P (HLV.L. 0 3 mm. Al)	100 K. V.P. (H.V.L. 1.5 mm. Al)	140 K.V P (HLV L. 2 mm. Al)	140 K.V P (H V L. 0 4 mm. Cu)		
0 0.5 1 2	100 35 17 6	100 67 53 34	100 80 63 43	100 88 79 63		

TABLE 2 — Tolerated Roemforn Dorage for Portal Areas in Single Applications of X rat

	100-140 L.V P	*00 K.V P
	(HV_L,18 mgs_Al-	(III L QB
Bquare	0 4 mm. Cu)	mm, Cii)
Centimetera	R.T D 18 Cm.	8 T 1) 25-50 (m.
1	3 500 r	
:	3 400 r	
4	3 000 r	
8		2 000 r
6	2 500 r	
10 20 40	2 400 r	1 800 r
20	2.200 r	I 600 r
40		1 500 r
100		1 400 r
150		1,350 r
200		1,300 r

tions of x ray (Table 2) Skin overlying bone or cartilage in the groin, axilla gluteal or perneal folds will react more severely especially for the larger ports. In these areas, a safer dose would be from 10 to 20 per cent less

There are seldom any indications for angle dose technic with 200 kilovoltage peak x ray except to postoperative small recurrent breast carcinoma or superficial lymphomas where it is impossible for a patient to return for fractionated treatment. In many of these cases, a single dose to satisfy the convenience of the patient is not always to the best interest of that patient.

Failures with the single dose technic may be due to madequate desage and/or faulty applica-When this occurs, it is most important that any further irradiation be preceded by careful estimation of the causes of the failure. Should the dose be considered too small, then another application may be given. If the first dose was adequate, eg, basal cell carcinoma-3 000 r with half value layer 2 mm, aluminum, the recur rence is usually at the periphery due to madequate field size. Here, more irradiation might lead to permanent necrosis if the fields overlap Repeated treatment for failures is strongly ad vised against. Other methods, such as surgery should then be tried. Due to some specific physsologic condition, such as an irregular or poly ploid chromosome number, some tumor cells may be resistant to a single dose of radiation, and these cells, along with their radiation-induced fibrous stroma, may attain a still greater remstance to further radiation 1 It is certainly much better to admit a radiologic failure in time to effect a surgical salvage than to end up with a





Fig. 3 Small squamous cell carcinoma of lip before and after treatment.

condition where neither radiation nor surgery is of any benefit.

From experience, it is known that a single application of 1,500 to 2000 r (half value layer 1.6 to 2 mm. alumnum) has cured a great many small squamous and basal cell carcinomas of the skin. It is also recognized that a greater percentage of cures will follow 2 500 to 3,500 r applied tion. The following two cases will illustrate

Cass 1—This patient had squamous cell carcinoms of the lower lip (Fig. 3) A 140 kilovoltage peak (half value layer 2 mm. aluminum) skin target distance 18 cm. 1 500 r to a 2-sq cm. field dose was given. Although this dose is small there was no recurrence over a period of twelve years. Today this losion would be treated more safely with fractionated technic. If this were impossible, a single dose would be 3 000 r

Case ? —This patient had basal cell carcinoma on the left ade of nose (Fig. 4) A 140-kilovoltage peak (half value layer 2 mm. aluminum) skin target distance 18 cm 1 600 r to an 8-eq cm. field does was lesion such as this. Since only partial regression occurred, another 1 600 r was given six weeks later No recurrence in eight years was the result. This illustrates faulty dosage and technic This lesion, today would receive the fractionated treatment described in the following pages.

Multiple or Divided Dose Through One Port.— Depending on the size of the leason e.g., larger than 1 cm in diameter, thickness, e.g. 1 cm and/or the presence of specialized tissue in the





Fig 4 Basal cell carcinoma, side of nose, before and after treatment

treated field, eg, lip, tongue, soft palate, or laryna, the radiation should be applied in repeated sessions in order to reach a level lethal to the cancer cells but tolerable by the normal tissue bed. Since normal tissue, because of its longer resistant cell phase, recovers from radiation faster and more completely than malignant tissue, such a regime is necessary. Thus, a favorable balance is kept between the repair and damage processes in both types of cells

The total dose applied through one port will depend upon the quality, size of port, skin target distance, and increments and their time spacing The border surrounding the lesion should be wide enough to insure irradiation of the most literally extended cells (Table 3)

TABLL 3 -Size of Margin of the Lesion

	Margin around Border of
Diameter of	Border of
Lesion	Lesion
1 cm	0 5 cm
3 cm	1 0 cm.
5 cm.	1 5 cm.
10 cm	2 5 cm.

It is sometimes well to include slightly larger margins should the clinical picture indicate this

In the treatment of cancer, the normal skin, mucous membrane, and subcutaneous tissue will react very intensely but will recover with some permanent changes from the following fractionated doses of x-ray (Table 4) As in the case of the single dose, skin or mucous membrane overlying bone or cartilage in the groins, axilla, gluteal, and perineal folds will react more severely. In these areas the safe tolerance dose might be from 10 to 20 per cent less, especially when larger ports are used

When a skin target distance of 50 to 80 cm is used, the amount of radiation listed above may have to be reduced, especially for field sizes over 50 sq cm. This causes more underlying tissue to be irradiated with resultant immediate and late vascular changes. This affects the skin both directly and indirectly.

In treating through a single port with qualities of radiation from half value layer 2 5 to 9 mm copper at a skin target distance of 50 to 80 cm the advantage of greater skin tolerance for similar roentgen doses is minimized by the greater depth intensity. If a lesion is deep enough to indicate short wavelength irradiation, it is usually much better to cross fire it. Attention always should be given to the possible deep tissue changes when short wavelength radiation is used.

TABLE 4 -- FRACTIONATED DOSAGE ACCORDING TO PORTAL SIZE

<u></u>		
Field Sıze	100-140 K.V P (H V L. 15 mm Al 04 mm. Cu) S T D 18 Cm.	200 K.V P (II V L 0.0 mm. Cu) 9 T D 25-40 Cm
2-10 Sq Cm.		
In 5 Days for	0 14 4 000	
Shallow Lesions In 5 Days for	$3 \times 1,000 \mathrm{r}$	
Thick Lesions	$3 \times 1500 \mathrm{r}$	
In 10 Days	5 × 1 200 r	
5-20 8q Cm.		
In 9 Days		$8 \times 600 r = 4800 r$
In 12 Days		$10 \times 500 r = 5,000 r$
In 17 Days In 26-28 Days		$14 \times 400 r = 5600 r$ $20-22 \times 300 r = 6000-6,600 r$
40-50 Bg Cm.		== 22 % 500 1 == 0 000=0,000 1
In 6 Days		$5 \times 600 r = 3000 r$
In 9 Days		$7 \times 500 r = 3500 r$
In 12 Days		$10 \times 400 \text{r} = 4000 \text{r}$
In 19 Days		$15 \times 300 r = 4,500 r$
100–150 Sq. Cm In 4 Days		$4 \times 600 r = 2400 r$
In 7 Days		$6 \times 500 r = 3000 r$
In 10 Days		$8 \times 400 r = 3200 r$
In 15 Days		$12 \times 300 \mathrm{r} = 3600 \mathrm{r}$

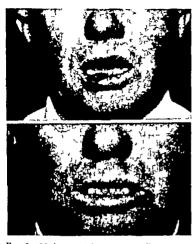


Fig. 5 Moderate-sized squamous cell carcinoma of the lip before and after treatment

It is often necessary to change the dose increment as the treatment course progresses. For example, with intrinsic larynx carcinoma stage I, the increment is increased gradually from 200 r to 600 r while the field size is decreased from 6 by 8 cm to 3 by 3 cm. A total single port dose of 7,600 r is given in 18 increments within twenty days. The dose at 2 cm. depth is 6 000 r (400 kilovoltage peak, half value layer 5 mm copper)

Increments may be spaced irregularly according to the biopsy control indications (tumor cell destruction and intercellular reaction). This requires strict individualisation which every radiologist should endeavor to practice. Koller and Smithers' work along this line is most in teresting.

The following 2 cases illustrate fractionated treatment through one port.

Cose 5 —This patient had a small carcinoma of the lip (Fig. 5) A radiation does of 200 kilovoltage peak (half value layer 0 9 mm. copper) skin target distance 40 cm., 13 increments of 400 r was given within fifteen days Port decreased from 3 by 6 cm. to 1 by 3 cm. The total surface dose comprised 5,200 r The total 2-cm. depth does was 3 800 r There was no recurrence in three years

Case 4.—This patient had a large cardinoma of the lip with enlarged, hard submaxillar, nodes (Fig. 6) Four hundred kilovoltage peak (half value layer 5 mm. copper) skin target distance 70 cm. 16 increments of 300 r within eighteen days was the deage given. The field mise was 10 by 15 cm. The total surface dose given was 4 800 r and the total 5-cm.





Fig. 6 Large squamous cell carcinoma of the lipbefore and after treatment

depth dose was 3 552 r Heavy lead was used over the laryngotracheal neck area. There was no recurrence over a period of three and a half years.

Cross Fire Technic -- In order to deliver a suitable dose to deeper tumors at is necessary to utilize more than one entrance port or beam so that these beams may converge at the point of Thus, an addition of two or more pathology depth intensities results At the same time one or all of the beams may leave the body at the entrance point of another beam. In this case the skin or mucous membrane will receive not only what went in from its beam but what came out from another beam. The beam at the point of its exit is softer than at its entrance, and if the exit skin is in contact with table mattress the intensity is slightly greater than if the exit skin is clear The addition of the entrance and the exit roentgens should always be recorded

The amount of radiation delivered in the depth under these conditions also should be accurately recorded. This is why it is important that the radiologist make a sound estimation of the depth and size of the pathology before treatment. The anatomic plane of therapy may have to be

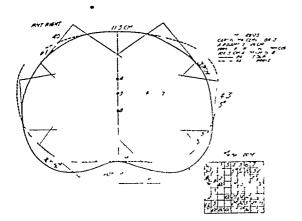


Fig 7 Treatment diagram of carcinoma cervix, group III (League of Nations)

sketched in life-sized dimensions so as to plot with isodose charts a suitable technic of application (Fig 7) In the estimation of the depth dose it is well to keep in mind the difference in energy absorption of the various tissues which the beams traverse Isodose charts, which are used routinely in this institute, are based upon water and presdwood phantom measurements Muscle has about the same atomic composition as these experimental phantoms, whereas fat is much lower and bone much higher quently, there is less energy absorption in the fat and much more in the bone The energy absorption in bone is least in the supervoltage and gamma wavelengths For this reason, it is better to use short wavelength radiation where beams must pass through bone to reach pathology, eg, lateral pelvic ports in carcinoma of the cervix

Since the depth dose will depend upon what can be delivered safely through the entrance ports, it is important that these entrance ports be of such size, position, angulation, and separation that the depth dose is brought to an optimum amount, while the deeper normal tissue doses and the entrance portal doses are within recoverable amounts. It is also important to consider the lateral scattered radiation outside the beams, since these may converge in such an amount that important normal organs in the vicinity of the pathology, e.g., the eye in cross firing an antrum, may receive more radiation than intended

Since every deep malignant tumor is attached to or surrounded by normal tissue, even a greater regard for safety should prevail than in the case of a more accessible lesion. In other words, the total dose delivered to the cancer area must be within the limits of the recovery factor of normal tissue. In cross fire technic the integral or volume dose is very important. Since this is directly influenced by certain technical factors, a

short discussion is in order. Anything that will decrease the constitutional effect but still keep the tumor dose at an optimum should be done. Besides the size and arrangement of the fields used, the integral volume dose is influenced by the skin target distance and the quality of the dose.

Ellis reported that, in the treatment of carcinoma of the esophagus, the integral dose with a skin target distance of 40 cm was 25 per cent greater than with a skin target distance of 100 cm when other treatment factors were identical ²

Phillips' work is quoted from Wilson as follows ²

In the treatment of carcinoma of the rectum by 1,000 kilovoltage peak (half value layer 9 mm copper) x-ray at 100 cm skin target distance, "the average integral dose is about 40 megagramme roentgens and produces definite impairment of the patient's vitality, from which recovery occurs in about two months. At 200 kilovoltage peak (half value layer 2 mm copper) the integral dose would be over 60 megagramme roentgens—which would almost certainly impair the patient's vitality to a critical degree."

A limit control of tumor dosage will no doubt spell defeat in many instances where, by the use of multiple ports, a cancercidal dose may be delivered, but only by jeopardizing the life of the normal tissues and/or the life of the patient. This point may be exemplified by some cases of infiltrating carcinoma of the urinary bladder. Here, it is usually impossible for the normal part of the bladder to withstand the dose that could be delivered to and could destroy the cancer. Hence, in some clinical cases, it is better to use surgical methods if it is realized that the cancer will not respond to safe dosage.

In practice, the total amount of radiation tolerated in the depth depends upon the site and tissue volume treated and the time period con-With two right and left neck 3 by 3 cm ports (200 kilovoltage peak, half value layer 09 mm copper) at 50 cm skin target distance, it is possible to deliver 6,000 r to the laryngeal cord area in 28 treatments within thirty-two days However, in the treatment of a cervix carcinoma by cross firing with four to six 10 by 15 cm ports (200 kilovoltage peak, half value layer 0.9 mm copper) at 80 cm skin target distance, the safe depth dose in a 20-cm diameter pelvis might average only 4,000 r to 5,000 r in the same space Again, in the treatment of carcinoma of the cervix, it is advisable to place a limit upon the total roentgens (both x-ray and gamma) applied to this area within a certain limit of time It has been the practice at this institute to deliver no more than 8,500 r to 9,000 r, e.g., x-ray 5,000

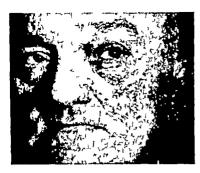


Fig. 8. Skin of left check showing changes nine veurs after cross fire irradiation of carcinoma of antrum.

r, plus gamma 3,500 r, to the cerva area within thirty five to forty days

It may be said that a total of 4 000 r to 7 000 r delivered to the tumor site by x ray, whether by two or six ports, will be about the best desage telerated by tissue bed when given within a period of four to seven weeks with equal spacing of increments. The following two cases serve to allustrate this

Case 5 —Carcinoma of left antrum was treated with 200 kilovoltage peak (half value layer 0 9 mm copper), cross fired by left cheol port (85 sq cm.) at 50 cm. akin target distance and intraoral port (9 sq cm.) at 40 cm. skin target distance. The increment with back scatter, alternating one port each day was 400 r. Twelve check and 13 intra oral treatments within thirty-five days were given Total does to check skin was 0 092 r (increment plus exit) to intraoral palate gum, 7 585 r (increment plus exit) and to the center of pathology, 6 858 r Figure 8 shows skin of check nine years after treatment with no recurrence.

Case 6—Carcinoms of cervix, Stage III (League of Nationa) was treated with 1000 kilovoltage peak (half value layer 9 mm. copper) cross fired by any pelvic ports anterior, postenor lateral right and left, 10 by 15 cm. area at 70 cm. skin target distance. Separation and angulation can be seen in Figure 7 Six hundred roentgens (with back scatter) were delivered to one port each day with 7 cycles occurring within seven weeks. The total roose to the center pelvis was 0 678 r and to a point 8 cm. lateral to the center point was 6 888 r and to a point 8 cm. lateral to the center point was 6 888 r and to a follows an atterior 4 536 r posterior, 4,284 r and lateral, 4,200 r Radium delivered to the cervix amounted to 2 500 gamma r There was no recurrence.

Conclusions

1 Radiation doeage in 'roentgens with back scatter' must be identified by the anatomic

site, radiation quality, and the amount and time spacing of the delivered increments.

2 The radiologist should examine each patient before treatment and in cooperation with the referring specialist should determine the question of curability or pulliation. If neither is apparent, no radiation should be given

3 Dosage must be large enough to cause a cancencidal effect without undue hazard to the vitality of the normal tissues and life of the ratient

hursen

4 Failures should not be blamed upon dosage unless all other technical factors of application are considered competent. This includes the personal factor

5 Biologic response is due to the radiation that is absorbed by but not necessarily delivered to the cell. Clinically, this includes both cancer and normal bed cells. Much experimental animal irradiation, both in vitro and in vivo, has shown results comparable to clinical experience

6 Although there is no specificity in wavelength, the ratio of the physical roentgen dose to biologic roentgen dose as manifested by the skin

erythema, will vary with the quality

7 The integral volume dose should be kept to a minimum. In deep-sented lesions this can be done by using as short a wavelength as long a skin target distance, and as small a field as possible

- S In cross fire technic, if the exit and entrance ports coincide their addition in roentgens (all though the beam is softest at exit) must be recorded and considered in akin reaction dose. A comparison study with 1 000 kilovoltage peak (half value layer 9 mm. copper) and 200 kilovoltage peak (half value layer 0 9 mm. copper) is reported.
- 9 Radiosensitivity and radiocurability are not synonomous. The anatomic grading of a tumor is more important than the histologic grading. The lymphoma series is the most radiosensitive Practically all other cancers must be treated as intensively as is considered tolerable to the normal tissue bed
- 10 The specific minimum number of roentgens (with back scatter) necessary to destroy any human cancer is not known accurately. The numbers of roentgens (with back scatter), toler ated by human tasue under some technical conditions, have been listed. Variations, of course, exist. More individualization in radiation technic is advocated
- 11 For all but the small accessible lesions fractionation and cross fire technic are indicated. The entire desage problems dependent upon the clinical experience of the radiologist. Better knowledge of technical factors pertaining to this

subject will, in the future, improve radiation end results

Discussion

Louis C Kress, MD, Buffalo—This presentation not only discusses radiation dosage but also the role of the radiologist in the control of cancer Any of you who have visited Dr Murphy's department at the Institute will be impressed with the range of x-ray generators at his disposal and with the meticulous care with which this therapeutic agent is applied

Every radiologist should examine the patient before treatment is given. This is demanded of the surgeon, regardless of who refers the case, and yet, radiologists treat patients without making a physical examination. What is more, some take a special pride in stating to the patient that they do not perform physical examinations. A radiologist is a physician and should examine the patient and familiarize himself with all the clinical and laboratory data concerning the patient. Only in this way will good radiology be available to the patient and keep this specialty of medicine from disrepute. There must be cooperation with all concerned in the treatment of a cancer patient.

A point which Dr Murphy stressed was that radiosensitivity does not mean radiocurability, many tumors are radiosensitive, but are not curable This radiosensitivity is, in some instances, designated by the pathologist However, he might easily be wrong, for sensitivity can be truly ascertained only after radiation therapy has been applied in sufficient quantity and with proper technic The referring physician should be acquainted with what the radiologist hopes to do for the patient Few referring physicians realize that x-ray therapy may be used as a palliative procedure as well as for Yet, when radiation fails to cure an advanced cancer, this therapy is frowned upon The referring physician must become acquainted with the limitations of radiation

The radiologist, too, must know not only his own limitations, but also the limitations of the generator or generators at his disposal Dr Murphy has stated clearly in the text of his paper that the output of an x-ray generator depends on the kilovolt-

age and the filter used There is a marked difference in the output between the 45,000 and the 1,000,000 volt x-ray generator. All patients with malignant disease cannot receive adequate treatment with a 200-kilovolt generator. The size of the patient alone precludes this, especially if the tumor is deep seated. In order to eradicate the tumor completely, all cells must be destroyed. Thus, while the 200 kilovolts may give palliation, the higher voltages may effect a cure

Many patients who receive x-ray therapy do not receive proper supportative treatment. This is just as much a requisite for the x-ray patient as it is for the surgical patient, and is probably neglected because of the lack of beds and because the patient is not educated to this procedure. The results of x-ray therapy could be enhanced if all patients received this supportative treatment before, during, and after radiation. It is hoped that in the near future, sufficient hospital beds will be available to make this possible

The tumor clinics throughout the State should treat those patients which the staff of the tumor clinic feel can be treated at their own clinic Here. again, limitations must be recognized There is sufficient clinical material available for all because cancer in upstate New York is of great magnitude. The Roswell Park Memorial Institute has been designated by the Tumor Clinic Association of New York State as the "mother clinic" The Institute is prepared and now able to fulfill the designation in every sense of the word There must be a correlation of program between the Institute and the tumor clinics If a patient is beyond the scope of the staff of a given clinic, that patient should be sent elsewhere This means that every physician must become acquainted with the tumor clinic nearest him In that way, the patient who can be treated in a local clinic will be so treated, if not, he can be referred to another clinic or to the Roswell Park Memorial Institute

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PHYSICIANS ART AND LITERARY EXHIBITIONS

The American Physicians Art Association and American Physicians Literary Guild will have exhibitions during the American Medical Association Convention June 21 to 25, 1948, on the US Navy Pier Over 200 cups will be awarded winners

in the various types of art, and engraved plaques for the successful contestants in various classes of literature For detailed information write to F H Redewill, M.D, executive secretary, 526 Flood Building, San Francisco, 2, California

THE DOCTORS BECK OF SCHENECTADY AND ALBANY

ELLIS KELLERT, M D Schenectady, New York

(Ellis Hospital Laboratory)

ENIUS has been defined variously as an in finite capacity for taking pains, as originality in thought and ideas, as a natural aptitude to perform easily that which others do with great difficulty. However regarded, it certainly is of rare occurrence, and repeated studies have been made to discover, if possible, some formula for its appearance. Havelock Ellis, who investigated British men of genius, obtained some interesting facts but concluded that the basic reasons for the appearance of genius are beyond our ken. That faculty appears where least expected and no more often in the great centers of culture and population than in the lowly town or village and even the isolated farm.

Skills may be transmitted within the family group, and Galton showed that intellectual ability tends to run in families. Talent is more likely to be inherited than genius, and fortunate, indeed, is that potential genius who has not been inhibited by the instructional system of the period and made to conform to the prevailing method of learning so often merely experimental and evanescent Students of a hundred years ago had many advantages Everything in science was new and experience the quickest and best teacher The successful teachers were those who encouraged free thought and experiment Since great capacity seldom appears more than once in a given family, its advent in three brothers all siblings, merits special attention.

In the late years of the eighteenth century most of inhabited America extended from the Atlantae Coast to the Alleghanies. Beyond was wilderness. In those tormented postrevolutionary years, when there was considerable doubt as to the continued existence of the new republic, that comparatively small area along the Mohawk and Hudson valleys was continuing its important role in the making of the nation, a role out of all proportion to its minute size and population area was in a ferment of trade and politics Economic self-sufficiency in America and large scale industry were envisaged and concrete plans of transportation facilities, such as canals, bridges and roads through the wilderness, were proposed The towns were small, with populations of about 3 000 in Schenectady and 10 000 in Albany

The small but not sleepy village of Schenectady witnessed the marriage of Caleb Beck and Cather

Presented at the 14lst Annual Meeting of the Medical Society of the State of New York, Buffalo Session on the History of Medicine May 8 1947 me Theresa Romeyn Catherine became a widow at the age of 29, and to her fell the task of guiding and educating her five sons Education was a dominant note in the family, in fact, Catherine's father was a founder of Union College All her sons followed learned professions, two studied law and three became physicians and scientists of international fame Nowhere else in early American history do we find a similar record

One may well pause here and dilate upon the character and virtues of Catherine Romeyn Beck This ambitious, intelligent, clear-minded, hard working mother gave all to her recognized function in life Her persistence, capabilities religiosity, and natural talents, so characteristic of the Dutch in the valleys of the Mohawk and Hudson were responsible largely for the development of her sons She talked little but did To those who now prate volubly about character formation and the role of the church. schools, and social agencies, we may say-conalder the mother of the Becks She taught by example always the best method with the young She not only kept the home but studied her sons' lessons with them, continually lending encouragement, support, and hope

The source of Catherine's drive and capacity is readily traced to her father, the Rev Dr Derick Romevn He was an intense patriot who was charged with the crime of "preaching liberty" and who had a price set on his head by the British Obliged to flee from Hackensack and Ecopus when those places were captured, he was accompanied by Catherine and ultimately ar nved in Schenectady, where Catherine married Caleb Beck and where all her sons were born It would not be difficult to form a mental image of this determined energetic, gracious woman Her vigor and ability may be readily seen, for none of her children died in infancy during a period of inadequate samitation, high infant mortality, and low-grade medical services. There were few medical schools worthy of the name and no hospitals outside the large cities. Any quack could set himself up as a physician and regular doctors were licensed by the county medical societies with all the attendant abuses of this arrangement That three accomplished and productive physician brothers should have developed out of such an environment is worthy of study and record

Our account begins with Theodric Romeyn Beck, the eldest of the brothers, who became most eminent in the field of medicine although highly qualified in natural science. He was born in Schenectady, August 11, 1791, graduated from Union College in 1807, and then studied under the famous Dr. Hosack of New York following the preceptor custom of the day. He received his degree in 1811 and began practice in Albany. This was a year before the first house was built in Rochester and five years before Clinton's Ditch, as the Eric Canal was called, was begun

Theodric Beck lived from 1791 to 1855, a highly constructive period in American life and one in which the fires of scientific accomplishment had begun to burn brightly The people in general were intelligent and exhibited a great desire to progress, especially in applied science Most communities had popular science organizations visited frequently by peripatetic lecturers, many of national and international fame Communities competed for these visits and for the establishment of various schools of learning Thus, obscure little villages became the homes of medical schools, and it was to one of these, the Fairfield Medical College or the Pioneer Medical School of the Western District of New York, that Beck lent his name and talents As a member of the faculty, he lectured on mineralogy and medicine

Theodric Beck became principal of the Albany Academy from 1817 to 1848, during which period Joseph Henry was connected with that Academy as professor of mathematics and natural philosophy One recalls that it was Henry who discovered the electromagnet, that principle which initiated the present great electrical age, fostered by the largest electrical industry in the world and also situated in Beck's native city of Schenectady While principal of the Albany Academy for almost thirty years, Beck wrote many papers on medicine and general science and lectured frequently to the lay public on scientific problems In all his discussions he entered into the history of the subject, realizing that the intelligent pursuit of a topic required a knowledge of what was already known

Beck was regarded as a stimulating teacher and held in high esteem, for he also was second vice-president of the board of trustees of the Rensselaer School in Troy, the precursor of the Rensselaer Polytechnic Institute and the first school of science to be established in New York. In 1815, he began a course of lectures on medical jurisprudence at the Fairfield Medical School in Herkimer County, and, as his knowledge of the subject expanded, he felt it a public duty to write a comprehensive work on this branch of medicine In 1823 Beck published his great classic, The Elements of Medical Jurisprudence, for which he is best known and which is quoted even today

That work, issued in two volumes of 471 pages, was the first comprehensive exposition of the legal aspects of medical practice to be published in the English language. It marks the beginning of the specialty of medical jurisprudence so prominent today. It attained international fame and translation into many foreign languages. The Jurisprudence, which passed through five editions in thirteen years and eleven editions in all, has been the model for all subsequent books on forensic medicine. It is replete with carefully collected data and original observations and is remarkable for its wealth of practical information, insight, and logic

The Jurisprudence was dedicated to the medical profession In casting about for a title for the book, Beck inclined to prefer the term, "State Medicine," which today is used widely to mean medical practice under government control His early trend toward the study of forensic medicine was the result of attending a course of lectures by Dr James S Stringham of New York, also a student of Drs Bard and Hosack. Throughout the work Beck emphasizes the necessity for the careful study of sudden and obscure death by trained investigators, but even today most of the nation still operates under the antiquated, crude, unscientific coroner system with its high percentage of failures and obstruction to justice

While the Jurisprudence was Beck's most notable written contribution, he was eminent in other respects He pointed out the mineral riches of the United States and the possibility of their exploitation by manufacturers ganized the State Library in Albany and the State Cabinet of Natural History, which was the beginning of the present State Museum He became secretary of the state board of regents, an office he held for many years He actively assisted Alden March in organizing the Albany Medical College in 1839, became professor of materia medica in 1840 and lectured on medical jurisprudence He urged physicians to study chemistry, anatomy, and pathology, spoke up strongly for compulsory vaccination against smallpox, and was active in the improvement of sanitary conditions Beck was only twenty-four years of age when he began his lectures at Fairfield and only thirty-two when the Jurisprudence was published Men matured early in those days Contrast that with the present situation in medicine when the student is about thirty as he leaves the schools and hospitals to embark upon his career, already fatigued by a heavy curriculum and exhausted by the anxiety induced by the methods of many teachers of medicine.

Theodric entertained a high regard for medicine and its practitioners He realized its limitations and frequently urged conference, recording, organization, and experimentation. He taught medicage for thirty nine years but actually practiced only ax years In 1817 when he became principal of the Albany Academy he gave up practice, which he disliked although expressing his delight with the study of medicine Everything in natural science interested Beck. wrote on the mineralogical resources of the United States, the marble quarries in Benning ton, Vermont, on fossil remains called tralobites, on the bituminous coal of Trogo, Pennsylvania and, with Amos Eaton, published a geological survey of the County of Albany All these papers were published between 1813 and 1820 and Beck had received his medical degree in 1811

In 1829 T. R. Beek became president of the Nedical Society of the State of New York. So successful was his administration that he was elected twice again. Theodric a first presidential address considered all phases of legal evidence and commented on the hydrostatic test for respiration in the dead newborn infants. He made many suggestions, hoping "they might lead to discussion and improvement".

In the second address he pleaded for more pathologic research and called attention to the uncertainties of churcal diagnosis He referred to the last illness of George Washington, who was thought to have died of laryngitis in these words "Where was the instruction to guide the practitioner?' He paid tribute to the pathologist who, "proceeds to his high office at the risk of health-often indeed of existence' In his third annual address, he spoke on smallpox and put up a vigorous defense for compulsory vaccination In refusing a fourth nomination to the presidency, he said, "The distinction of addressing you whould not long be continued in one individual ' He realised that presidential dissertations by the same person might become tedious even boring

In 1855, Theodric came to the end of the trail but he was a scientist to the last, observing his symptoms and the phenomena of dying hard breaking the cham-is not this a long struggle how long have I been in it? he asked of his daughters at the bedside. Noting the signs and symptoms of his ailment and attempting to interpret them he realised that his doctor friends who thought he was suffering from a 'failure of assimilation, ' had not made a correct diagnosis He remarked. I have thought my case over it is a remarkable complaint don't you When the doctors attempted to encourage him in the usual unconvincing fashion, he asked the direct question that the physician bears every day 'Can you get me well? autopsy he was found to have "essified coronary arteries," a lesion rarely noted in those early days but common in the present era

Like all the Becks, Theodric was a kindly man. helpful, progressive, and the highest type of citizen. He spoke up against oppression and in justice, whether practiced by corporations or individuals. His period, too was called a progressive age, with important ovents in science and government succeeding one another rapidly When the last moment came he said he felt blest in closing his eyes upon a country prosperous, united, and happy That was five years before the War of the Rebellion. He was active in every movement to improve science, medicine, art, government, and education Not only did he assist greatly in the formation of such schools as Fairfield, Rensselser Polytechnic, and Albany Medical College, but he was instrumental in obtaining state appropriations to enable the versu tile Edmund Bailey O Callaghan, also a physician. to carry on his translation of the old Dutch historical papers, a truly monumental accomplishment The Becks made Albany one of the most important medical centers in the country

Louis Caleb Beck was the third oldest of the brothers, but second in importance, and lived from 1798 to 1853 When he was but six months old his father died and Louis was completely under the guidance and influence of his capable and resourceful mother From her as one biographer wrote, 'He early developed a love of nature, neatness exactness, firmness, and decimon.' He might have added intellectual honesty, an outstanding trait of all the Becks. He graduated from Union College in 1815 and chose Dr Thomas Dunlop of Schenectady as his preceptor for about a year. He then studied at the New York Hospital of Physicians and Sur geons and in 1818 was licensed by the Medical Society of Albany County Like his elder brother, Theodric, he wearied of the crude methods and ignorance prevailing in medical practice and decided on a scientific career in which he was encouraged by Theodric. These two brothers were remarkably close until the ends of their lives, temperamentally alike, and completely objective in their approach to all problenis.

As a preliminary, Louis visited his brother Abram in Missouri in 1810. Travelling by steam boat from Albany to New York, he crossed the mountains on horseback to the Ohio and then by flat-boat to St. Louis. Being an excellent observer he noted while passing through the wilderness the natural resources and the best sites for towns and cities, and today we find the cities established on these very sites. Louis published a book on the natural history of Illinois and Missouri which became a model for similar studies throughout the nation. He later wrote in detail of the saft springs at Syracuse and on the commercial potash deposits of New York State

Louis Beck was a prolific writer for his time and the list of his contributions is a long one. His most important work was Mineralogy of New York State, the result of seven years study and one of the chief factors enabling New York to become the Empire State, for his study pointed out the natural wealth of New York and its manufacturing possibilities This was the period when the first railroad was established between Schenectady and Utica and Saratoga, but Beck had to travel by coach and horseback over the state, 14,-606 miles in all He wrote on mosses and ferns in the United States, on the adulterations of drugs and foods and then detection, on the botany of the northern and middle states, on cholera, then prevalent in New York State, and on that peculiar and then frequent disease in the middle west, milk sickness, from which the mother of Abraham Lincoln is said to have died

He published a manual on chemistry and, in collaboration with Joseph Henry, published a scale of chemical equivalents, Beck being responsible for the atomic weights. At that time there were but 53 known elements amazed Beck would be today to see the list of elements, especially the radioactive ones, and to learn that man actually has created elements that had not existed previously-neptunium, americium, and curium He even wrote on religion and temperance During these years, Beck lectured at Rutgers College, Berkshire Medical College in Pittsfield, Massachusetts, the Castleton Medical School in Vermont, the Fairfield Medical School, and the Rensselaer Polytechnic Institute was active in forming the Albany Medical Col-In the latter school he taught chemistry and pharmacy, and, over a period of many years, taught simultaneously in Albany and at Rutgers in New Brunswick, New Jersey

Let it be recorded here for the benefit of our political friends in Albany that in 1818, at the instigation of T R Beck, Governor Clinton invited Amos Eaton, then president of the Rensselaer Polytechnic Institute, to give a course of lectures on geology before the state legislature What a wonderful tradition to try maintainingto instruct the lawmakers through the medium of recognized experts before the enactment of haphazard legislation to the detriment of the public and the public purse! Eaton, a fine scientist, was convincing, for subsequently there was appropriated \$104,000, a huge sum in those days, for the survey of the natural resources of New York Through the influence of T R Beck, the work was entrusted to Louis Beck, who already had attained eminence in the field of science through his study of the natural history of Illinois and Missouri, and who had exhibited his orderliness, system, and knowledge in prior studies on

These virtues, doubtless, were inculcated in his pupil, Asa Gray, of Utica, the eminent botanist and friend and correspondent of Charles Darwin It was about 1750 that the remarkable physicianscientist, Cadwallader Colden, a former heutenant-governor of New York State and intimate of Benjamin Franklin, wrote to the naturalist Gronovius of Holland, favoring a system in botany that showed a graduation from one class to another and from one genus to another through almost imperceptible stages This was the "natural" system used by Louis C Beck in his scientific writings and the same type of classification used by Darwin in the Origin of Species L C Beck's Botany of the Northern and Middle States marked an important advance in the teaching of botany

Louis Beck's publications and interests were numerous. Among his many teaching connections was one with the Fairfield Medical College, situated near Little Falls. Fairfield had a brilliant faculty, one worthy of a metropolitan school. They were real teachers and investigators and most stimulating to students. It was at this medical school that students administered ether, the protoxide of oxygen gas, to themselves in 1838, eight or more years before the first public demonstration by Morton in 1846 of the anesthetic properties of ether.

Here it was that Asa Gray came to study medicine, listened to lectures on botany by Beck, and remained to teach botany In one of his letters he wrote, "Dr Louis C Beck used to come and deliver a short course of lectures on botany He gave this up in the year I received my M.D., and so Professor Hadley invited me to come and give the course instead " Gray thus was launched as a botanist and, in 1848, published his Manual of Botany, which is still used by botanists as the basis for the classification of plants And so Asa Gray, pupil of the Becks, became, as stated by Howard Kelly, "almost the creator of North American botanical science" Gray was an active correspondent with Darwin, to whom he gave solicited data, and whose theory of evolution he accepted although he was a genuine theist Gray conditioned the American public for acceptance of the Origin of Species, a task Darwin assigned to him Although Asa Gray became a world famous botanist, his thesis for his MD degree was on "Gastritis"

In 1848, Congress became interested in the foods of the country and appropriated funds for the chemical examination of food stuffs. The task was assigned to Louis Beck, who investigated breadstuffs and published his results in the US Government reports. This work appears to be the beginning of the Federal government pure foods and drugs activities. Louis studied correls from regress ports of the country and

found that southern wheat contained more gluten which with albumen, was considered to be the most nutritious element in bread. In those premicrobiologic days, he urged that more attention be paid to drying and ventilation of wheat to prevent its becoming moldy and sour. He identified a long list of adulterants used in bread and certain drugs, with methods for their detection.

Louis Beck was a scientist and writer of the first rank, easily comparable to Louis Agassia, the naturalist. He exerted a profound influence on the course of education and botame science in the United States. He was an excellent teacher and organizer, extremely industrious and a man of great integrity His students could not but be impressed and influenced by his learning high ideals, and intellectual honesty Beck's talents were exerted through the Fairfield School, the Vermont Medical Academy the Berkshire Medical College, the Medical School at Rutgers in New Jersey, and the Albany Medical College His students were numbered in the hundreds and they were the men who spread out through the states to practice medicine, to build new medical colleges and hospitals

The Minerology of New York was his last and most important work Louis Beck died in 1853 survived by six children None however be-

came physicians

Dr John B Beck was the third in rank of this trio of eminent physicians He hved from 1794 to 1851, and was noted as a teacher and writer To the Medical Jurisprudence by his brother, Theodric, he contributed the important chapter on infanticide. In that item he brings out sig milicant points for determining whether or not an infant was alive at birth facts that are valid today in similar investigations He gives an interesting summary of the history of infanticide its almost universal prevalence in ancient and mod ern times. While it was practiced almost every where, he could find no mention of infanticide among the North American Indians corded another of the many virtues of the abong ines of this continent A discussion of infanti cide is meeparable from that of abortion and our forensic and hospital records of today indicate that the practice is still common among the most civilized (?) and social-minded peoples

In eliciting proofs of the dead child's having been born airve, Beck states that the circulators of the blood is the vital principle. In agreement with the eminent Bichat, he notes that blood in the arteries and voms has the same appearance and resembles venous blood that blood in the pul monary vessels indicates that respiration had taken place Collapse of the ductus venous, blood in the ductus arteriesus, and ecchymoses on the body all indicate respiration and so enable the lung to float on water Before respiration the

lungs weigh 1/m of the total body weight, and after respiration but 1/m of the weight of the body, the increase being due to the blood admitted to the lung when respiration began

John Beck graduated at Columbia College with highest honors in 1813 and studied Hebrew in London, probably having in mind the ministry, but soon thereafter began the study of medicine under Dr Hosack of New York He received his medical degree at the College of Physicians and Surgeons in 1817 where he subsequently became professor of materia medica and botany John wrote for his graduation thems a treatise on infanticide, later writing on the absorption of medicines into the blood and, also, on infantile therapeutics

His chief contribution, as already mentioned, was the chapter on infanticide in the Medical Jurisprudence by T. R. Beck. In that article he discussed in detail the signs present in death before and after birth and the hydrostatic test, which, unfortunately, was opposed by the eminent William Hunter. The prestige of Hunter prevented the general adoption of this test over a period of years and worked considerable injustice in many cases that came to court. Dr. Beck also wrote on deaths from poisoning in New York history of medicine in the American colonies, and the use of ergot. John never married

The other two brothers were lawyers, Abram lived in St. Louis, and Nickolas F died at the age of 30 while adjutant general of New York.

Thus is concluded this brief account of the Doctors Beck of Schenectady and Albany the works of these men one perceives the evolu tion of science and science teaching in America. Their activities made the Capital District one of the most important medical centers of the United States, a position which the area still holds, not because of enormous schools and hospitals but because of vital scientific discoveries. These brothers from the little village of Schenectady properly may be regarded as important founders of American medicine, for they were largely in strumental in creating those conditions out of which developed such men as Theobald Smith, foremost American medical scientist graduated from the Albany Medical College in 1883 when that institution still felt the influence of the Becks, Smith developed into one of the most brilliant medical investigators of modern times

Out of this same region there came later notable contributions in neurology, gynecologic pathology, ophthalmology, cardiology, and radiology The Capital District has been foremost in the fields of medical education and medical research and doubtless will remain so in the rapidly developing field of atomic investigation for the cure of disease.

HISTORY OF SURGERY IN ROCHESTER, NEW YORK

RICHARD A LEONARDO, MD, FICS, Rochester, New York

(From the Monroe County Hospital)

YTHE end of the eighteenth century, several B'small communities had become established in the Genesee River Valley, despite the prevalence there of Genesee fever, typhoid, smallpox, and other epidemic diseases Scottsville, Tryon, King's (later Hanford's) Landing, Frankfort, Irish Dublin, Carthage, and Charlotte were but a few of these settlements, most of which are now part of the incorporated City of Rochester first white settlers in what is now Rochester were "Indian" Allen and his three wives lotte, the port of Rochester, the first settlers were the William Henchers and their seven daughters, all of whom married there However, in spite of these auspicious starts, no community had much chance to develop there, because, as explained on the tombstone of Gideon King, "The Genesee fever was mortal to most heads of families in 1798 and prevented further settlements until about 1815" And, adding insult to injury, "Indian" Allen and his three wives moved to Canada when their mills burned down

Nevertheless, in spite of the local unsanitary conditions (or, perhaps, because of them) young doctors began to flock to Rochester The first physician there was Dr Jonah Brown It was in 1813, when the Ontario wilderness lay prostrate with fever, when the sick and dead were carried off in ox carts as if from a battlefield, that Dr Brown began his work. As you can imagine, life was far from easy for him For the first year or two, the floor was his bed, his saddlebags were his pillow, and his horse blanket his covering

Dr Brown married Huldah Strong, sister-inlaw of the postmaster, Abelard Reynolds She
was the first schoolmistress in the village Sometimes she helped her brother-in-law in the post
office, and sometimes she was barmaid in his
tavern One author has woven a romance around
the time when Dr Brown allegedly was attacked
by a "panther" at the Rapids It was likely,
he wrote, that the doctor, after such an encounter, felt the need of a stimulant and dropped in
at the tavern, thus beginning a successful courtship Dr Brown served the early settlers for
twenty-three years before retiring

From the beginning, Rochester has been well supplied with doctors In 1821, the sixteen physicians practicing there organized the Monroe County Medical Society The first Directory of Rochester, published in 1827, contains the names of 27 doc-

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tors, one for every 320 persons! All were general practitioners and included surgery and obstetrics in their services. When a new doctor came to the village, he advertised in the daily papers. Dr. Hartwell Carver, for instance, in the Rochester Telegraph, informed "the public that he has settled himself as a physician and surgeon at Murray Four Corners, where he will attend to all calls both in the practice of physic and surgery and particularly to all operations in surgery."

A tattered and yellowed Physicians' Fee-Bill, perhaps the earliest authentic document in the medical history of Rochester, issued by the Monroe County Medical Society on May 17, 1827, will be referred to later. The early minute books of the society, which might have been a rich source of information, were burned many years ago. The only present available data about Rochester's pioneer physicians and surgeons are contained in the early village newspapers and in the published reminiscences of old residents.

An important signer of the Fee-Bill and, also, president of the County Medical Society, was Dr Frederick Backus—He was graduated from Yale University, with both academic and medical degrees, and then attended the Medical School of the University of Pennsylvania, virtually obtaining the best medical education then available in the United States—Backus was far in advance of his time in that, according to his own report, he used ether by inhalation as early as 1817, or twenty-nine years before Morton

In 1814, another Yale graduate, Dr Freeman Edson, came on horseback from his home in New England to Watertown, New York, where he Finding it expected a position awaited him already filled by a veteran of the War of 1812, he continued his journey through the dense forests of western New York, looking here and there for a suitable place to open an office Passing by the lone, log cabin of Hamlet Scrantom at the present site of the City of Rochester, Dr Edson pushed farther into the wilderness until he came to a small clearing about twelve miles beyond, where he found his uncle, Isaac Scott, and his namesake village of Scottsville, now a suburb of Rochester There he settled

Dr Edson was a strong, rugged man of untiring energy, as he had need to be, often he had only "snatches of rest" for several days at a time. He was an expert at extraction of teeth and, in spite of his extensive practice, he kept up with the times, especially in surgery. He was the first within a wide region to perform successfully the

operation of trophining. Even after he was ninety years old he removed a tumor from a patient's face. In 1882, when Dr Edson was ninety-one years old he addressed the students of Indiana Medical College, telling them how to live a long life. His stirring words traveled throughout the country with the statement that he was thought to be the oldest practicing physician in the United States.

Another interesting character in the early history of Rochester was Dr. Archelaus Green South who arrived in 1823 during the height of an epidemic. Dr. South acquired his medical education the 'hard way'. After toiling all day in the field be studied by candicilght in the yillage post office.

He was an athlete, standing six feet in lus stockings, and could walk under a clothes line with his shoes on and turn about and jump over it. I He soon had so large a surgical practice that lie was called "Butcher" Smith. He performed many unusual operations such as removing a tumor the size of a hen's egg from the nostril of a young man

He was always eager to learn something new, but there came a time when Dr Smith was wor ned and annoved A patient had wasted away and died despite his most strenuous efforts. Thinking he might learn the cause of death from a postmortem examination Dr Smith like the great anatomists of old, went in the dead of night to the place where his patient was buried and returned stealthily to his seeluded workshop with a heavy burden on his shoulders, the dead body of his patient. He made his examination sur reptitiously, for it was a time when dissection was a crime punishable by law When he had learned all he could, he mounted the skeleton and concealed it in a closet.

Years passed, and no trouble developed until one day a relative of the deceased woman caught a glimpee of the skeleton and claimed he recog mized it by fillings in the teeth. Dr Smith was arrested Feeling that conviction was inevitable he provided for relays of horses every five nules between Rochester and the Canadian border in order to escape punishment for doing what he believed was right and necessary The day of the trial came. The dentist was summoned to identify the fillings but, becoming confused, he testified that the fillings "were on the right in stead of the left side of the jaws.' The corpus delicts being unestablished the case was dismussed and Dr Smuth acquitted 1 The waiting horses were not needed In 1828 the law was repealed and dissection legalized

An important surgeon announcing lus arrival in the community in 1837 was Dr Edwin George Munn In Scottsville he had practiced as a general surgeon but his work as an oculast was

so overwhelming that when he came to Rochester he devoted himself entirely to ophthalmology. The first dental surgeon in Rochester judging from nowspaper advertisements, was Dr. Horidio Fenn

Another carly surgeon was Dr Simon Hunt a resident of fever-stricken Hanford's Landing who later moved to Rochester Dr Hunt had been a surgeon in the War of 1812, in Isaac W Stone a hastily assembled Dragoons, when the British arrived at the doors of Charlotte It is written that Dr. Hunt attended the little daugh ter of Hamlet Scrantom soon after the arrival of the Scrantom family in 1812 the first family to settle in Rochestorville permanently The daughter had broken her ankle, and the neighbors, two or three miles distant, came "to offer assistance or to enjoy the unwonted excitement ' This was the first surgical operation performed in the settlement, and it took two hours Dr Hunt also was one of the signers of the Fee-Bill of 1827

By this Fee-Bill, the surgical procedures com mon at that time are indicated as follows: price of a hip amputation was \$75, amputation of the shoulder joint \$50, amoutation of the larger limb \$30, and of the digits \$5, removal of the breast cost \$25, and of the testicle, \$20, the charge for reducing dislocations and fractures was \$5 to \$15, the extraction of cataract cost \$50 and obstetric attendance, \$5, with an additional 50 cents for each hour over twelve hours. harelips were repaired for \$10 hernias reduced for \$5 or operated upon for \$30 The bill further states, 'syphilitick cases not to be prescribed for till \$5 be paid ' The name of anyone who refused to pay his indebtedness was entered in the Black Book, and no physician was supposed to attend that patient until his account was settled with the other physician.

Toward the middle of the nineteenth century. important changes occurred with the discovery and use of anesthesia. Rochester a medical group was passed almost unnoticed, credit for the discovery being given to Morton, primarily, and to Wells Long and Jackson Yet when William Thomas Green Morton was traveling in the middle west by stagecoach canal boat, or train with the pack of a Yankee peddler with goods for farmers a young chemist and premedical student William E Clarke was entertaining his friends at No 8 Arcade Building Rochester, with experi ments and demonstrations of "Magnetic Sleen and 'Somnambulic Condition.' This was in 1839 In the same year, William Morton, with his pack, reached Rochester and, hearing of these 'ether frolics, attended one, and, apparently for the first time, learned of sulfuric other, according to Lyman' and to the October 1946 issue of More Books 3

Later, in 1841 and 1842, Clarke attended Berkshire Medical College and continued his ether entertamments for the benefit of his companions there In January, 1842, Dr Clarke, having returned to Rochester as an MD, administered ether from a saturated towel to a young woman named Hobbie, and Dr Elijah Pope, a Rochester dentist, extracted her tooth without pain 4 This caused Dr John A Benjamin, of the University of Rochester School of Medicine, to remark that "this 100th anniversary (1946) well may have been four years too late since Clarke's use of ether would appear to be the first use of ether anesthesia on record It antedates by a few months what presently is known of the work of Dr Crawford W Long, a young Georgia physician, who did not publish his work until December of 1849 "

Claim of an even earlier use of ether anesthesia in Rochester was made by Dr Frederick F Backus ⁵ The minutes of the Monroe County Medical Society, published in the Union and Advertiser on November 17, 1849, state society met at the Court House on Wednesday last, at ten o'clock in the forenoon, the president, Dr W W Reid, in the chair Dr Backus. as chairman of the committee on obstetrics, read an interesting report on cases of midwifery attended by himself from 1832 to 1849 Among other interesting statistics connected with these cases was the number of births in seventeen 712, males 386, females 326 years, viz

"During his report Dr Backus mentioned that he had used ether in his practice, by inhalation, in the year 1817, so it would seem that neither Dr Morton nor Dr Jackson is entitled to the honor of the discovery, though we presume Dr B will never court contention on that point"

Another pioneer surgeon of Rochester was Dr W W Reid, well known for his original method of reducing "dislocation of the femur on the dorsum ili," within two or three minutes by simple manipulation, as reported in 1851 in the Boston Medical and Surgical Journal His first successful case was in 1844, his second and third in 1849, the latter a patient of Dr Edward Mott Moore's, who afterwards remarked that, "Hereafter any fool might reduce dislocations of the hip on the dorsum ilii"

Dr Edward Mott Moore is considered the most advanced and outstanding surgeon Rochester ever had In 1830, Moore studied with Dr Anson Coleman, Rochester's leading physician He was graduated from the University of Pennsylvania Medical School in 1838, interned at Blockley Hospital, and, with Dr C W Pennock, did original experimental work on the heart

Thereafter, he returned to Rochester and soon became the recognized leader in surgery in west-

ern New York, including Buffalo He served as professor of surgery at Woodstock, Vermont, at Starling Medical College, Columbus, Ohio, at Pittsfield, Massachusetts, and at the University This necessitated his giving two or three months each year to teaching Dr Moore also lectured on anatomy and on fractures and dislocations His article on dislocation was considered a masterpiece of original work writings on "fracture of the collarbone, the wrist, and the upper end of the arm" contained remarkable observations and contributions to surgery, "the correctness of which has been proven by vray workers" It is said to have been a source of great satisfaction to Dr Moore, late in his life, to have his views regarding the nature of Colles fracture confirmed by the roentgen ray Moore's experiments on transfusion of blood resulted in valuable observations, as did his views on sanitation He promoted a movement for a system of city sewers and for pure drinking water from Hemlock Lake, the source of Rochester's present water supply

His work in the prevention of contagious diseases led to his appointment as the first president of the New York State Board of Health thirty years he was chief surgeon at St Mary's Hospital, and was active also in the organization of the Rochester City Hospital, now the General Hospital, and the Infants Summer Hospital He was once president of the American Medical Association, president of the Monroe County Medical Society, of the Medical Association of Central New York, of the New York State Medi cal Society, of the American Surgical Association, of the Rochester branch of the American Red Cross, and other local organizations president of the Board of Trustees of the Univer sity of Rochester, and delegate to the International Medical Congress in Copenhagen his most outstanding and lasting works was the establishment of the park system of Rochester, reputedly one of the best in this country cause of his love of open spaces and natural beauty, the bronze monument which was erected in his honor in 1927 was placed in Genesee Valley Park overlooking the Genesee River

Almost forgotten today is Rochester's early medical school, the Central Medical College, Eclectic, which was moved to Rochester from Syracuse in 1849, with Dr William W Hadley as dean In 1847, Hadley was a druggist in Rochester, but when he returned to Rochester from the Cincinnati Eclectic College, with an M D after his name, he devoted himself most energetically to the cause of eclectic medicine Although not held in high esteem by the allopaths, the eclectics served a good purpose by opposing bloodletting and other harsh remedies and substituting simple

regetable products. This interest in botany as applied to medicine developed when an embargo and the closing of ports forced pharmacists to search for remedies at home. Soon Dr. Hadley had a following of several practitioners, who met in Minerva Hall, at the corner of Main Street and South Avenue, and he lectured to a group of students there.

Dr Hadley was known as professor of materia medica, therapeutics, and pharmacy and his fame spread to Symcuse, where he became visiting professor at the medical school. Some financial difficulty arose in the Symcuse school and it was decided to transfer the school to Rochester. The reasons given by the Rochester newspinjors were that Rochester had a hospital which might be of advantage, that Rochester had attractive botanic sardens for the study of botany, and that 'the acknowledged moral and literary character of the inhabitants of Rochester' was such that the cause would be better advanced.

The Edectics admitted women to their school at that time a revolutionary movement. In the session of 1850-1851, ten of the 53 students were women! In addition to his other duties Dr Hadley published the monthly New 1 ork Edectic Medical and Surgical Journal One article com paring the work of the two sexes, called attention to "the thorough and faithful devotion of our lady students to actual dissections knowledged that "our female students have proven themselves equal to any of the opposite sex." Yet, in the height of success, in 1853 the school and its professors disappeared afterward, Dr Hadley went to Brooklyn where he held several offices in eclectre organizations and was a professor and then president at the Felectic Medical College of New York City

Many women doctors in Rochester have attained eminence in the face of severe prejudice Following close in the footsteps of Elizabeth Blackwell was an eighteen-year-old Philadelphia Quakeress, Sarah Adamson, looking for a place where she would be allowed to study medicine While visiting her uncle, Dr Hiram Corson she had discovered a volume of Wistar's Anatomy in his medical library, "which she found far more interesting than the current novels young girls were reading in her day" She thereupon decided to become a doctor Her uncle disapprov ing, she started her medical reading in another doctor's office More disturbed yet over this new situation, Dr Corson saved the family honor by allowing her to study in his own office Later he endeavored to arrange her entrance into one of the Philadelphia medical schools Two refusals were encountered when a welcome announcement was made by the New Central Medical College, beleetie, at Rochester, that it would accept

women students "on equal terms with mon' Sarah Adamson at once left for Rochester and entered this school in 1851. Two years later she was graduated—the second woman in the United States to earn the M D degree.

After receiving her degree, Sarah Adamson went to Blockley Hospital, Philadelphia where she was the first woman intern then she returned to Central Modical College to marry young Dr Lester Dolley who held the chair of surgery there. Combining two careers she practiced in Rochester for sixty years as an obstetrician

No other physician of Rochester suffered as tragic an end as Dr Louis Weigel, who came here from the University of Maryland in 1875 as a specialist in orthopedic surgery He soon became one of America's most noted surgeons, serving on the staffs of the Rochester General and St Mary's hospitals and occupying the chair of orthopedic surgery at Ningara University His greatest work began with the discovery of the x ray Al rendy an accomplished amateur photographer, he was prepared for experimenting in radiography His discoveries in this line and in the use and value of the roentgen rays extended his fame throughout the United States and Europe These experiments, which he conducted without regard for personal safety in spite of the constant warnings of his colleagues, led to his early death malignant growth developed on his hands, necessitating the removal of all his fingers on one hand and three fingers on the other Five more opera tions were performed at intervals, and eventually he lost both hands, yet he continued his work unceasingly with a remarkable fortitude and courage Three years before his death, Dr Weigel had as his guest the world-famous Dr Adolf Lorenz of Austria who during his stay in Rochester conducted a clinic at St Mary's Hospital. Dr Weigel was also consulting orthopedic surgeon to the New York State Hospital for Crimpled Children at Yonkers and to the Crain Colony for Epileptics at Sonyea He was presu dent of the American Orthopedic Society and president of the Rochester Academy of Medicine

Rochester was without a hospital until 1845 when an organization of women rented quarters and opened a hospital for friendless sick persons. The hospital was incorporated in 1847 and was known as the City Hospital, now the Rochester General Hospital Soon afterward, the municipal council donated an old cemetery on West Main Street and the first building was completed in 1862. Dr Henry Dean was the first physician on the staff of the hospital, in 1846, and the first surgeon was Dr Harvey F Montgomery, who held that position for twenty years. Dr Charles F Rider, eye and ear surgeon, was the first specialist of the hospital Many improvements

and additions have been made during the one hundred years of the hospital's existence

Almost as old is St Mary's Hospital, established by the Sisters of Charity in 1857, with Dr Edward Mott Moore as chief surgeon—In 1891, the hospital was almost entirely destroyed by fire, and a new one with accommodations for 300 patients was erected on the same site—Recently, adjoining land was acquired and an entirely new hospital built

In 1889, the Rochester Homeopathic Hospital, now the Genesee Hospital, was opened first surgeon was Dr J M Lee, whose first operation was the removal of a stone from the bladder, The hospital was prepared for surgery from the beginning That same year, Dr Joseph Biegler founded the Hahnemann Hospital, now the High-One of his wealthy patients from New York City gave \$10,000, and the hospital at first was called the Hargous Memorial Hahnemann Hospital Dr Biegler, being a homeopath, had founded the hospital almost exclusively for medical treatment, little expecting that the time would come when in one year alone several thousand surgical patients would be received

A private hospital was established in 1894 on Park Avenue by Dr John F W Whitbeck It was closed from 1904 to 1907, when it was reopened by Dr Charles R Barber, and in 1921 it was incorporated as the Park Avenue Clinical Hospital Dr W Douglas Ward, one of its surgeons, was the first in Rochester to construct an artificial vagina by using a loop of intestine

As various wars have been fought, Rochester has furnished its share of surgeons. As only one family lived here at the time of the War of 1812. the volunteers obviously enlisted from the nearby In World War I, the Rochester settlements General Hospital sent Base Hospital No 19 to France, and, in World War II, General Hospital No 19, which recently returned from France and Germany under the command of Colonel Edward T Wentworth Both carried on their staffs some of the leading surgeons of Rochester also must be made of the contributions of Dr Stafford Warren, professor of radiology at the University of Rochester, who was a key man in the development of the atomic bomb, being medical safety director for the Manhattan Project

The last hospitals to be added to Rochester's list are the Strong Memorial and the new Municipal. These are associated with the School of Medicine of the University of Rochester, which was dedicated in 1926, the gift of George Eastman. Dr. John Morton, chief of the surgical staff, his assistants, and the Rochester surgeons on his staff have made the hospital outstanding for its surgical procedure and research. However, they would be the first to admit that no startling

discoveries nor highly original and exclusive surgical procedures have resulted yet from their very conscientious operative work and surgical experiments. Some of the more important surgical contributions of this school are the following

Dr John J Morton and Dr W J Merle Scott did important basic work in congenital megacolon and in peripheral vascular diseases, as well as devised important preoperative tests to foretell results of sympathetic denervation Dr Herman E Pearse devised a suitable vitallium tube as a substitute for the common bile duct Dr Clyde Heatly did considerable work on esophageal and laryngeal surgery, especially in hemi- and total Dr Forest Young did much laryngectomy successful work in plastic surgery, especially in reconstructing ears by using pieces of rib cartilage. chopped up and put into a vitallium mold, and burying the mold in the abdominal wall until the pieces were fused together by connective tissue Drs Forest Young and Benedict Favata worked on the thrombin and plasma clot to hold down skin grafts, thus making a physiologic cement Dr T B Jones did some important work on liver function, Dr W P Van Wagenan worked on the value of brain surgery in diabetes insipidus Drs Willard Allen and George W Corner did a great deal of original work on ovarian hormones and their relationship to pregnancy Dr Plato Schwartz made original stabilizing operations on the foot and original work on the electrical recording of the human gait, and he also confirmed the Sister Kenny conception of the existence of muscle spasm in muscles involved in poliomyelitis, and finally, important results were learned in experiments using blind loops in dogs to determine the toxic factors in cases of intestinal obstruction

In spite of these excellent achievements, I regret to say that as yet the faculty of the University of Rochester has been unable to organize a systematic course of lectures on medical history to warrant the creation of a chair there. This is no fault of the University, however. Dean George Whipple told me a few years ago that the University would be glad to create a department on medical history as soon as a special and sufficient endowment had been received.

Also regrettable is the fact that usually it is only the older physician or surgeon who becomes interested in medical history and pursues it in its original sources. Yet, if such courses were taught in American schools as they are in many European universities, many more doctors would appreciate the true worth of such a cultural and philosophical study. Not only does it give fundamental knowledge on the evaluation of the whole art of medicine, but saves considerable time and effort in medical research and experimental study.

It is not surprising therefore, that the average American medical graduate today is totally ig norant of the processes by which the art and so ence of medicine have attained the pre-eminence they now occupy And, for those physicians whose avocations lie in creative writing, there is no better background material for any book in the medical field than a knowledge of medical history

Thus, the need for giving our young practitioners an acquaintance with medical history is great. We hope that through our University our future doctors will main a reasonable knowledge of the glories and triumphs of medical history

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TREATMENT OF HYPERTHYROIDISM WITH PROPYL THIOLIRACII.

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(From the Thuroid Clinic and the Medical Service of the Bronx Hospital)

IN 1943, Astwood used thiouracil in the treatment of human thyrotoxicosis and found that it produced lowering of the basal metabolic rate, gain in weight, and return of the patient to normal health. These findings have been confirmed by Williams and his coworkers and others so that the efficacy of thiouracil as an antithyroid drug was well established 2-4

However, thiournell has proved to be a somewhat toxic drug About 15 to 20 per cent of the patients who received the drug showed some toxic manifestations. The most serious complications were drug fever and agranulocytosis. The inci dence of drug fever varied from 3 to 5 per cent Agranulocytosus occurred in 1 to 2 per cent with a total mortality of 0.4 per cent in a series of 5,475 Cases 4

In an attempt to overcome thiouracil toxicity different compounds containing thiouracil were synthesized One of these is 6-n propyl thiouracil * In this paper we wish to report clinical results and impressions gained from 51 cases of thyrotoxicosis treated with this drug

At first, the desage consisted of 25 mg of propyl thouracil given 3 to 4 times daily However we soon found that this dosage was insufficient, being extremely slow in causing a remission of thyrotoxicosis. Furthermore, patients who were satisfactorily controlled by 300 mg of thiouracil had an exarcerbation of their symptoms when placed on 75 mg of propyl thiouracil daily After two months of employing this small dose we increased the dosage of propyl thiouracil to 150 mg per day (50 mg 3 times a day) Even with the latter dosage, we found that propyl thiournell acts at a considerably slower rate than thiouracil

Our experience with propyl thiouracil to date. reveals that it is much less toxic than thiouracil It had to be discontinued with 1 patient because of a febrile reaction. One patient had mild headaches which disappeared after a few days. This same patient also had peculiar pain in the iaws and muscles of the face Two patients had mild gastrie upsets Practically all of the toxic manufestations of propyl thiourneil occurred within six weeks after the institution of therapy

Most of the patients responded within ten to twenty-one days as manifested by the ameliora tion of the thyrotoxic symptoms This delay is believed to be due to the time taken by the body to use up the preformed store of thyroxine. As with thiouracil, patients who had had previous iodine medication responded more slowly

To date, we have had no case of agranulocyto-Four of the patients developed a leukopenia with a leukocyte count going down to 4,000 per cu. mm. or below The dose of propyl thiouracil was cut in half, or the drug was omitted for one day The count rose, and the original dose of propyl thiouracil, given before the leukopenia developed, was resumed. In a survey of the literature only 1 patient was found to have developed agranulocytoms. **

However, we still feel that it is necessary to do frequent blood counts on patients who are receiv-

^{**} This was a case of Dr Elmer Bartels, as quoted by Dr W E Astwood, at a lecture given at Mount Sinai Hospital, New York City on April *5 1917

^{*} The propyl thiouracii used in this study was supplied by Laderle Laboratories, Inc., Pearl River New York, through the couriesy of Stanton M. Hardy M.D., medical director and Benjamin W. Carey M.D. director of laboratories.

and Benjamin W Carey M D director of aboratorica. This study was sonducted in the Thyrid Clinic and from the Madical Services of the Bronn Hospital New York Harry Weesley M.D., director Abnes Starn M.D., and Max Welzs, M D., attending physicians. We are indebted to Joseph Felson M D., director of laboratorice and research for his cooperation in this study.

and to Miss A. V Henderson, technician, for carrying out the metabolism tests and blochemical procedures.

ing propyl thiouracil A white blood count and differential blood count are taken once a week the first six weeks and every two weeks thereafter

Our patients are instructed to discontinue the drug and report to us if any adverse symptoms such as fever, sore throat, coryza, and malaise are experienced. We keep our patients on a maintenance dose of propyl thiouracil for at least six months after the basal metabolic rate has returned to normal.

We have found no aggravation of the exophthalmos or enlargement of the thyroid gland in any of our cases. In many there was a definite reduction in the size of the thyroid gland. Nodular goiters, contrary to previously expressed opinions, responded well to propyl thiouracil therapy.

We have had 4 patients, aged sixty-seven, sixty-four, fifty, and forty-one, who had auricular fibrillation. The last 2 returned to a normal sinus rhythm when the metabolic state reached normal. The other 2, although they have gained weight, lost all thyrotoxic symptoms, and have returned to a normal basal metabolic rate, are still fibrillating. Concomitant hypertensive heart disease may be the reason for the continuation of their auricular fibrillation.

Only I patient failed to respond to propyl thiouracil therapy. This patient had had a thyroidectomy several years ago, but the thyrotoxicosis persisted. She also failed to respond to thiouracil and iodine. She was receiving iodine plus propyl thiouracil, but we never succeeded in bringing her metabolic rate or pulse down to normal levels.

Case Reports

The following cases illustrate the action of propyl thiouracil

Case 1 —Mrs S F gave a history of thyrotoxicosis of over three years duration She was given Lugol's solution but developed erythema nodosum, and the iodine was discontinued She was treated then with radium and received 23 treatments without improvement

Physical examination, on June 27, 1946, revealed a 52-year-old white woman, 61 inches tall, weighing 106 pounds She had mild exophthalmos and generalized thyroid enlargement There was a fine tremor of the hands, and she was extremely nervous The skin was warm and moist The heart had a regular rhythm, the blood pressure was 130/70, and the pulse rate 105-110 per minute The lungs and abdomen were negative X-ray of the chest revealed no evidence of substernal thyroid The electrocardiogram revealed sinus tachy cardia Urine and blood were normal The basal metabolic rate was plus She was given propyl thiouracil, 25 35 per cent mg three times a day, and responded very readily on this dosage On July 30, 1946 (five weeks later)

her basal metabolic rate was 0 per cent, pulse was 76, and weight 111 pounds. Her nervousness and tremor had disappeared. She was able to resume her work and felt well. The dosage of propyl thiouracil was reduced so that on a maintenance daily dose of 25 mg, her basal metabolic rate varied between minus 8 to minus 3 per cent. Propyl thiouracil was discontinued on May 28, 1947.

Case 2—Mrs V E was admitted to the thyroid clinic on November 6, 1946 She gave a history of marked nervousness, weakness, and loss of 26 pounds in six months

Physical examination revealed a very nervous 32vear-old Negress She had moderate evophthalmos and diffuse enlargement of the thyroid gland skin was warm and moist, and there was a marked tremor of the hands The heart was normal in size with a rate of 112 per minute, and blood pressure was She had a hypochromic anemia with a hemoglobin of 60 per cent (8 7 Gm) and a red blood cell count of 3 27 million (The anemia was the result of menorrhagia due to a fibroid uterus) The basal metabolic rate was plus 56 per cent given ferrous sulfate for the anemia and 50 mg of propyl thiournell for the thyrotoxicosis sponded well Her pulse became normal after a month, and she began to gain weight (from 111 to 129 pounds in eighteen weeks) The tremor disappeared after four months She is well and doing her normal work

Case 3 —Mrs M A had symptoms of thyrotoxicosis for about seven years, but two months prior to admission she became very nervous and weak, lost weight, and could not sleep. She had 6 to 7 loose bowel movements daily. She had marked palpitation and drenching sweats.

Physical examination revealed a nervous and apprehensive middle-aged woman, 60 inches tall, weighing 122 pounds Skin was warm and moist She had a diffuse thyroid enlargement and slight exophthalmos There was a marked tremor of the She was fibrillating with an apical rate of about 150 and a radial pulse rate of 120 Her blood pressure was 180/90 She had moist rales at both lung bases Fluoroscopy of the chest revealed mild left ventricular hypertrophy The electrocardiogram revealed auricular fibrillation, left axis deviation, and a heart rate of 150 per minute Urine and blood were not remarkable The basal metabolic rate was plus 80 per cent

On December 28, 1946, she started propyl thiouracil therapy 50 mg four times a day Subjective improvement began three to four days following the inception of therapy Objective improvement was Her pulse dropped to 96 within three weeks rapid Her basal metabolic rate came down to plus 5 per cent within fourteen weeks and in the same period her weight rose from 122 to 137 pounds weeks of propyl thiouracil therapy her white count dropped to 3,400 The drug was reduced to 100 mg daily, and three days later, the white count rose to 7,650 She has been on 50 mg twice a day since (The auricular fibrillation that the patient had was paroxysmal in nature as her heart returned to a normal rhythm within two days)

Comment

Judging from the reports in the literature and our own observation, it is clear that propvl thiournell is an effective antithyroid drug ? * It is less to uc than thiournell but is slow in its action and takes about one and a half times as long to produce comparable results. While the patient is on the drug, the basal metabolic rate comes down at the rate of about 1 per cent daily patient may be ambulatory and not hospitalized

We do not as yet know how long the remission from thyrotoxicosis will be sustained after propyl thiouracil is discontinued. We have 3 patients with a sustained remission of five to six months Following theouracil therapy we have had remission of all thyrotoxic symptoms and signs for a period of fourteen to twenty nine months in 12 out of 18 patients. One of the 12 patients took thiournell for six months with complete remission of symptoms. Subsequently, she had 2 normal pregnancies without recurrence of the thyrotoxi costs. Four of the nationts with a recurrence of thyrotoxicosis received propyl thouracil and responded very well

Will propyl thiournell supplant thyroidectomy in the treatment of thyrotoxicosis? Much longer observation in many more cases have to be studied before this question can be answered proper however, to compare results obtained from the surgical therapy of thyrotoxicosis with

that of this antithyroid drug W P Vander Lann and Orvar Swenson recently reviewed 149 cases of Grave's disease treated surgically in the Peter Bent Brigham Hospital between 1933 and 1940 These pa tients had subtotal thyroidectomics following preparation with iodine. The mortality was 2.7 per cent. (This figure is in the lower range for hospitals in which general surgery is practiced) Eight and five-tentlis per cent of the patients had a recurrence or persistence of the thyrotoxicosis and 13 9 per cent developed hypothyroidism

Dobson, Seely, and Rose reported a mortality of 2 11 per cent in a series of 232 toxic cases from the thyroid clinic of Stanford University 10

Albright and Clute, in a series of 197 cases from the Massachusetts Memorial Hospital, reported a mortality of slightly over 2 per cent.11 While it is true that highly specialized thyroid clinics like the Lahey or Cleveland have a mortality rate of less than I per cent thyroidectomy in the average general hospital carries a mortality of 3 to 5 per cent.

Practically all thyroid clinics have now adopted either propyl thiourneil or some other thiourneil derivative, alone or followed by iodine, to prepare their patients for thyroidectomy. As already mentioned, most of the toxic manifestations resulting from propyl thiouracil therapy occur

within the first six to eight weeks Thus corresponds roughly to the time necessary to prepare the patient for thyroidectomy with propyl thiourneil It is apparent therefore, that the lowered mortality from thyroidectomy, following preparation with propyl thiouracil outweighs any possible hazard resulting from this therapy

To date several hundred patients have been treated with propyl thiouracil with no mortality and only minor toxic reactions * Thus, if the low toxicity reported so far, continues, we believe that we now have a drug which can control thyrotoxicosis with results that compare favor ably with subtotal thyroidectomy plications that follow thyroidectomy namely hypothyroidism, parathyroprivm, and vocal cord paralysis are done away with by this therapy

Summary and Conclusions

- Fifty-one cases of thyrotoxicosis, treated with propyl thiouracil are reported
- The response to this drug was comparable to thiouracil but slower in action.
- One patient failed to respond to propvi thiouracil
- There was no incidence of agranulocytosis, but there was a 2 per cent incidence of drug fever
- There was an incidence of 8 to 10 per cent of minor and fleeting toxic manifestations
- Frequent blood counts and careful observa tion of patients are advocated.
- On the basis of results reported in the litera ture and results which we obtained, we advocate the use of propyl thiouracil for the treatment of all forms of thyrotoxicosis
- Thyroidectomy should be reserved for those instances in which local pressure symptoms occur or where unsightliness of the neck is present Propyl thiouracil, followed by iodine for ton days when the basal metabolic rate has become normal should be used to prepare these patients for operation

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- * Since this a tiole was written, the authors have treated 31 more cases of thyrotoxicods. These were all treated with propyl thiouracil, with uniformly good results.

THE OPTIMAL PHYSICAL THERAPY FOR RHEUMATOID ARTHRITIS

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THIS paper is limited to observations on the treatment of rheumatoid arthritis in an endeavor to determine the optimal physical therapy and even, if possible, the specific physical therapy for various forms of arthritis. After an observation period of about four years we believe that we now can tell which type of physical therapy from which to expect the best result, which type is indifferent, and which type is valueless or even contraindicated in the treatment of rheumatoid arthritis

One gratifying result is that a certain number of arthritis patients, who had had other physical therapy for a long period, sometimes for many years, without any real benefit, could be discharged greatly improved following the treatment which will be described. In a series of 400 patients with rheumatoid arthritis we never had to deviate from our routine once it had been instituted. Satisfactory results were obtained in better than 90 per cent of the cases.

In order to rule out all other forms of arthritis, the diagnosis was made by the patient's clinical history and examination, typical x-rays, and laboratory, as well as microscopic, findings ¹

The management of our cases of rheumatoid arthritis consisted of medical treatment, orthopedic measures where indicated, surgery as needed, and physical therapy

Comparing the different types of physical therapy we used previously, ion transfer was found to be the most effective form for rheumatoid arthritis. Unpleasant sequelae to other forms of treatment, which we have since abandoned, led us to the perfection of our present technic.

Contraindications of Certain Procedures

Among our patients with rheumatoid arthritis who spent a vacation in a warm climate, there were some who felt better, but whose symptoms became worse again on their return home. This led to the conclusion, since proved erroneous, that their home climate was unfavorable for their conditions. We found the symptoms of these patients to be aggravated about two months after they left for the warm climate. If their stay was prolonged beyond this time, their condition was aggravated in spite of the initial improvement from heliotherapy in the warm climate. The

Presented at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo Session on Physical Medicine May 7 1947 wrong conclusion that warm climate is helpful for rheumatoid arthritis came from the observation that it is helpful for rheumatic fever and for triumatic arthritis, the differential diagnosis of the various forms of arthritis not always being made

We had a similar experience with the ultraviolet lamp. After initial improvement the condition became aggravated and had to be treated in a different way. This experience led us to the same conclusion, namely, that the ultraviolet light works in some way as an irritant, requiring a certain time for the damage to become obvious. Later on, we shall show the influence under which ultraviolet light, as an adjunct to other therapy, rapidly and extensively damages a patient with rheumatoid arthritis.

Diathermy is another procedure unfavorable for rheumatoid arthritis This was difficult to determine, because many patients felt well during the treatment However, in spite of the comfortable feeling while under treatment, the aggravation occurred later, usually in two months Our experience is in concordance with other chinics which by now have stopped using diathermy for rheumatoid arthritis, considering it an irritant According to our experience, cases which improve from sunlight or diathermy are arthritis due to rheumatic fever, traumatic arthritis, or osteo-Mechanical irritation is undesirable for any kind of inflammation This should be true for rheumatoid arthritis as well because it is an inflammatory condition Therefore, one must not use massage, or active and passive exercise, as long as the condition is active, these procedures are helpful in the last stage of rheumatoid arthritis only, when the condition has subsided

The above procedures cause irritation because they speed up pathologic processes possibility is the freeing of toxins Weiss stated that in the case of an arthritic joint, where the distant primary infection is still active, the blood stream is loaded with toxins 2 Bringing more blood to the affected part through diathermy may only serve to aggravate the condition Irritating physical therapy, just as other irritations, causes a breakdown of diseased red blood cells may explain the increase of anemia in cases of rheumatoid arthritis when an irritating form of physical therapy was used 2 That certain forms of physical therapy cause an aggravation of rheumatoid arthritis can be shown by the elevation of the sedimentation rate Goldstein noted that

patients with rheumatoid arthritis who had a normal sedimentation rate developed an elevated sedimentation rate after marching 4 or 5 miles 4

Physical therapy is contraindicated when administering certain other treatments at the same It is of utmost importance to keep patients undergoing gold treatment out of the sun light, sensitive subjects may develop conjuncti vitis or skin rashes. We saw the latter develop mostly on parts exposed to sunlight. This is another example of irritation when heliotherapy is used in an improper way We believe that in these cases the damage was not directly due to a summation effect of the gold present in the body Rather, the gold acted as a catalyst speeding up the skin damage We made another observation of irritation which is worth being noted Patients who have received gold injections followed by physical therapy frequently developed symptoms of unrest, nausea, diarrhea or headache This did not occur when physical therapy preceded injections of gold In our hospital, therefore we made it a rule not to administer gold injections and physical therapy on the same day

We found only a few procedures which were truly indifferent and therefore harmless. Baking and infrared light, if kept mild and used for only a short session, were among these. Due to their most superficial effect they cannot produce any

deep irritation.

Because an elevated sedimentation rate is the expression of various pathologic conditions with tissue breakdown, which must not be aggravated we consider an elevated sedimentation rate a contraindication for using diathermy

Significance of Ion Transfer

These unpleasant occurrences have caused us to abandon the usual trial and error method of selecting physical therapy for a given case and we have developed a system of treatment of our own. This was not difficult, since reports of beneficial results of ion transfer were being published in over greater number at the time. In perusing the literature on this subject, one notes that ill effects were never reported as long as it was kept within well prescribed limits. In the treatment of rheumatoid arthritis the preference of authors varies from sodium salicylate ion transfer to histandiae ion transfer. We attempted to develop a system for the selection of the drugs to be used in the treatment.

When an electric current is applied to the living organism, the body or parts of it become components of the electric circuit. The tissues present certain physical characteristics as conductors of electricity and show certain biologic effects. In living tissue the electric current produces two kinds of physical influences an ionic effect,

essentially chemical, and a thermal effect. It is the lonic effect which has proved to be more effective in the treatment of inflammation. The ther mal effect is irritating and, therefore, must be chiminated as much as possible

When a direct galvanic current passes through a solution in which an electrolyte is dissolved, a transfer of positive ions to the negative pole and of negative ions to the positive pole takes place. Body tissue acts like an electrolytic solution for the passing electric current, due to its intra and extracellular fluids containing dissolved salts. In addition, a movement of larger particles takes place, this is called cataphorosis. It consists of migration of nondissociated molecules, migration of particles above molecular size (colloids), and migration of small bodies such as erythrocytes or bacteria All of these particles travel under the drive of the galvanic current toward the pole with the charge opposite to their own A special form of movement is known as electro-osmosis, the transportation of water instead of electrolytes. colloids, etc. when the movement of the particles is prevented and when movement of water alone is possible. From this description we can appreciate what physical effects are desired in the treatment of rheumatoid arthritis. If at the same time we succeed in Leeping the thermal effect low enough to prevent the unwanted effect of tissue breakdown the best possible healing effect will be obtained.

The galvanic current as used for ion transfer, produces mainly an ionic effect, the production of heat is negligible if the amperage is kept low enough. Through empiric experience we arrived at a very low docage which minimizes the danger of galvanic burn but still has a good biologic result.

Both poles of the galvanic current have a vasomotor stimulating effect which is more irritating under the negative pole and causes a reduction of nerve irritability under the positive pole. Vasostimulation causes improvement of circulation and with it improvement in the nutrition of the diseased joint. The use of galvanic bath is a more intensive procedure which we preferred to the conventional application of electrodes in cases of polyarthritis. There must be a metabolic influence of the galvanic bath, because the patient as a whole improves, not only his joints

Solutions Used for Ion Transfer

It was reported that solutions used for ion transfer do not penetrate the skin farther than the stratum Malpighi. We are not ready as yet to explain why the beneficial effect goes much farther. In contrast to the usual procedure we vary the type of ion transfer during the course of treatment The acutely inflamed joint must first be treated for pain Therefore, in view of its analgesic effect our patients first received a series of treatments with magnesium sulfate ion trans-The use of narcotic drugs for ion transfer was then abandoned This method was so satisfying that it became part of our standard pro-Only very rarely did we have to give codeine by mouth for severe pain during the initial stage of the treatment According to Echtman, who first advocated magnesium sulfate ion transfer for painful bursitis, pain is caused by the disturbance in the hydrogen ion concentration, hyperemia, and edema 6 Magnesium sulfate ion transfer overcomes these factors We found all this applicable to the painful joints of rheumatoid erthritis also In acute inflammation a disturbance in the normal ratio of the concentration of hydrogen ion and to the concentration of hydroxyl ion takes place in the body fluids of the involved With increase of hydroxyl ions, the alkalimity rises and causes irritation and pain ionization with the magnesium ion causes the tissues to neutralize alkali, resulting in relief of The positive pole, to which the magnesium sulfate solution is connected, liberates oxygen from which acid is formed. The acid neutralizes the excess of alkalimity, i.e., the excess of hydroxyl ions, influencing the restoration of the normal ratio of the two kinds of ions The positive pole also acts as a vasoconstrictor resulting in decrease of hyperemia The indication for using magnesium sulfate ion transfer, therefore, is the acute, inflammatory stage with edema and pain

Sodium saliculate ion transfer has been widely used for all types and stages of arthritis ously, it cannot be effective for all the various pathologic pictures It has its definite indication, and, if used accordingly, the percentage of good results must be higher than reported so far Sodium salicylate ion transfer has the characteristics of the negative pole plus those of the salicylate Therefore, it acts as vasodilator inducing hyperemia, relieves pain which is due to vasoconstriction or lack of blood supply, relieves spasm, dispels nonpurulent effusion and extravasations by increasing circulation and stimulating absorption, relaxes and softens the tissues, has an analgesic effect, improves the nutrition of the tissues by increasing the circulation, and softens scar tissue Its action on the surrounding muscles is of high value This consists of promoting blood and lymph circulation, reducing the likelihood of adhesions, and speeding up recovery of the muscles to the point at which voluntary exercise can take over The indications for using sodium salicylate ion transfer are, therefore, spasm about an arthritic joint, pain due to vasoconstriction or lack of blood supply, nonpurulent effusion and extravasation, and thickening of joint capsules

The characteristics of histamine and mecholyl ion transfer are well known. Histamine ion transfer is indicated in cases of chronic rheumatoid arthritis with little or no pain and with thickening of tissues around joints. Its effect penetrates into the deeper structures.

Mecholyl ion transfer is indicated in cases where one needs an intense local action with a negligible systemic action

Magnesium sulfate was used in a 1 per cent solution, sodium salicylate in a 2 per cent solution, histimine and mecholyl were used in a 2 per cent ointment The duration of one session of treatment was ten minutes at the beginning. later on, it was gradually increased to twenty minutes In an empiric way we determined a dosage of 2 milliamperes, which was effective enough but no longer had any undesired thermal With this low dosage no side effect was encountered After a few minutes of treatment one has to reset the dosage of the current because polarization produces an opposing electromotive force, thereby increasing skin resistance

In order to treat more than one joint at the same time we used mutual connection of those joints requiring the same medication, or we used the galvanic bath, where the patient is immersed in a tub. Different medicines were used at the same session according to their indication as denoted by pain, inflammation, thickening, spasm, effusion etc.

Results

The technic described in this paper has given favorable results in more than 90 per cent of about 400 cases of rheumatoid arthritis. Cases of frozen shoulder due to rheumatic foci in the head of the humerus became freely movable after a few weeks of treatment. At times, together with other improvements, high sedimentation rates were found to return to normal within a few weeks. Other cases showed a rapid improvement of the anemia.

Case Reports

I should like to report on two of the more severe cases since they demonstrate so impressively the good results that were accomplished

Case 1—A 55-year-old white woman who, at the beginning of treatment, was bedridden with contractions of knees, shoulders, elbows, wrists, almost all fingers, and with swollen ankles and feet, of six months' duration. Her rheumatoid arthritis was noted two years previously. Competent treatment was of no help. Institution of our procedure produced gradual improvement. Her health is now

fully restored she works full time as a trimmer of hats and plays the mandolin in an orchestra

Case 2-1 48-year-old white woman with rheu matic soft tissue changes and phalangeal bone Now she has good function of her destruction The x ray examination demonstrates extremities conclusively the repair of the proviously destroyed bone by normal esseous tissue

Summary and Conclusion

- Proper physical therapy is an important part of the management of rheumatold arthritis
- Ion transfer using magnesium sulfate sodium salicylate, histamine and mecholyl represents the optimal form of physical therapy for the treatment of rheumatoid arthritis
- There is a definite contraindication of certain physical therapy procedures of which the sedimentation rate is a valuable indicator
- There is a certain order of procedure when administering drugs concurrently with physical therapy

Discussion

Walter S. McClellan, M.D. Saratoga Springs -The author has presented a careful review of the use of iontophoresis in the treatment of patients with rhenmatold arthritis. In emphasizing any particular program of treatment it is easy to lose sight of its relation to other programs of treatment. However, Dr Stengel has intimated a number of times that physical medicine in this condition is only one of the accepted types of treatment. I am sure some physicians would take exception to his statement that chrysotherapy is the choice of treat ment today, yet it indicates his recognition of the necessity of an all-round approach to the treatment in this condition

In stressing iontophoresis the author has left the impression that little benefit may be obtained from other forms of physical treatment. Personally I do not prescribe to the recommendation of the author that exercise and massage cause trouble. As the author has emphasized that exact programs must be established for iontophoresis so also must carefully controlled programs of exercise and massage be used, because there is no question that improperly applied exercise will prevent progress and in some cases do harm. I am in hearty agreement with his premise that diathermy is of no par tleular value for the patient with rheumatold arthritis. The same is true of excessive heat and baking. The application of moist heat in the form of packs which are not extreme in temperature namely at 100 to 110 F will many times give a great deal of soothing relief

While I have not personally had any extensive experience with the use of iontophoresis for these patients. I know that it has from time to time been recommended during the past fifteen to twenty years notably by a number of observers. It is my impression that there has been a fading onthusiasm for this form of treatment. It is possible that this fading enthusiasm has been due to improper appli cation, and I believe that the material presented today by Dr Stengel emphasizes the importance of resurvey from time to time of any program of treatment and also emphasizes the importance of a carefully applied technic. It is often found that in the hands of the investigator who reports the tech nic the results may be excellent but when applied by other workers the results obtained are not nearly as good. The reason for this may be a failure on the part of the other investigators to follow the program of the original worker exactly or it may be that the enthusiasm of the original worker may have colored the results obtained from the use of its particular treutment

I would like to know how it is possible in this form of treatment to separate the effects produced in the body from the passage of the galvanic current alone from those which may be produced by the Some favorable reports have been forthcoming on the use of low frequency currents without the added use of drugs particularly with the hydrogalvanie bath I believe that some and possibly the majority, of the effects produced by iontophoresis are produced by galvanic current gather from the author's presentation that the drug may intensify the ionic effect of the current

I do not believe that any program of treatment is 100 per cent successful when we are dealing with rheumatoid arthritis and I hope that Dr Stengel can give us a little more complete picture of his clinical results He has not included any basic plan of evaluation of results. The specific evaluation of results in treatment of patients with arthritis has been very unsatisfactory in the past. It is hoped that some common basis for consideration of the elinical changes may be developed which would be acceptable to all investigators in this field. Until such common acceptance occurs there will be con fusion regarding the reports of the effectiveness of

any therapeutic program in this field. I know the amount of work required in careful tabulation of information regarding the program of treatment in 400 patients with rheumatoid

arthritis. I hope that we may have more information in the future possibly with careful control study of a series of patients who were treated by similar technic using sodium chloride in place of the drugs discussed. This is frankly a large series and the word of a person who has had the oppor tunity of observing this many patients should be re-

ceived with considerable weight

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THE PRESCRIPTION OF OCCUPATIONAL THERAPY

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EACH year sees the increased use of occupa-tional therapy, but the manner in which patients are referred and the nature of the prescription which admits them to this form of treatment have not progressed proportionately physicians are familiar with the objectives and possibilities of occupational therapy, and, what is more deplorable, there are still physical medicine specialists who have been reluctant to accord to this branch of their own specialty the attention which it deserves When a patient is referred for physical therapy by heat and massage, the physical medicine physician insists upon naming the specific modalities and dosages to be employed He should also be alert to the prescription of specific modalities and dosage of occupational therapy, if for no other reason than that the Council on Physical Medicine of the American Medical Association has made it his responsibility

Occupational therapy is activity prescribed for remedial or preventive objectives. The prescription of occupational therapy is the selection of the activity or activities best calculated to relieve the patient of his symptomatic pattern. It must be directed at the improvement in the range and control of impaired functions of the mind or body and should state, as far as possible, the frequency or duration of, activity desired. Perhaps its chief difference from drug prescription lies in its progression, and, because of this, continued observation is implied so that prescribed graduation may be guided by patient reaction.

The four major areas of effect, attainable through the influence of occupational therapy, are remedial motion (kinetic), effort graduation (metric), tonus (tonic), and the mind (psychiatric) ¹ Although there is some overlapping of all these areas, each will be considered separately

Kinetic

The pathology or treatment of neuromusculoskeletal disease may result in inadequate muscle strength, mobilization, or coordination

Muscle power may diminish as the result of immobilization, denervation, or muscle pathology. Once the causative agent has been removed or become mactive, the restoration of power, commensurate with remaining innervated tissue, is indicated. The prescription for strengthening

Presented at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo Session on Physical Medicine May 7 1947 muscles with occupational therapy is similar to that of remedial exercise, except that gainful or productive tools are substituted for gymnastic apparatus or patterns of movement In remedial gymnastics, motion may be independent of equipment or only partially dependent upon it, in occupational therapy, the tool defines the pattern of motion The prescription of a craft tool permits the unconscious control of motion, demands less mental concentration on the mechanics of motion, and diverts attention to the activity itself The end disguises the means and permits prolonged motion without the monotony of concentration on the means 2 Accurate prescription requires the ability to analyze the motions required to use each tool effectively (kinetic analysis of crafts) in relation to joint range, energy passive motions, etc 3 It is not necessary for the physician to know the analysis of each tool or activity, since the therapist is trained to offer this service, but the prescription should include duration, frequency, effort, and precautions to be observed

Two anatomic structures can be mobilized by occupational therapy joints and scar tissue Each of these can be affected more rapidly by passive motion, and, hence, physical therapy should precede, or at least accompany, such procedures. The gains made by forced motion can, to some extent, be maintained by occupational therapy through active or passive joint motion. The principles of stretching employed by the manipulative surgeon or physical therapist obviously apply to occupational mobilization.

As a result of motor neuron lesions, prolonged immobilization, or interference with proproceptive reflexes, voluntary motion may be uncoordinated, and activities to overcome this condition should be prescribed. Coordination is also necessary for the amputee whose prosthesis may be regarded as a denervated member. Coordination is taught through the tedious process of slowly progressive muscle and motion re-education. Those patients who have never had coordinated motion must be educated rather than re-educated.

Because all the methods just described are based on application of kinesiology, this form of occupational therapy has been called kinetic. The term functional has been applied to this form of treatment in the past, and, although it is widely used, the author feels that it has led, and will continue to lead, to considerable confusion

because of its long-standing use in psychiatry in the meaning of nonorganic.

Metric

In the convalescent phase of cardiac or pul monary disease, the period is reached during which some return of active motion is indicated. The prescription must be graduated according to patient reaction. In order to control exercise or work output it is necessary to measure or graduate the energy expended. This can only be accomplished by measurement of the intensity of work, the duration of the work and the rest intervals between work periods.

If the work is properly graded from day to day and from activity to activity the energy expended can be increased gradually with the most economic and rapid attainment of the objective. The basis for increase is tolerance, and tolerance to work is determined by the reaction of the patient (fever respiratory rate fatigue, etc.)

The same principle applies to the members of the body. If a weak muscle is given too much work on any one day, or a convalescing joint is overexercised, pain or swelling will frequently result on the following day, and these are indications of overdosage. Occupational therapy can be used not only to improve work tolerance but to measure its progression and in that way furnish information of prognostic value. Because this type of treatment is so intimately associated with measurement, we have called it metric occupational therapy.

Tonic

When a patient has been or will be bedridden for a prolonged period, it may be assumed that those muscles normally used in walking standing, and sitting will undergo atrophy in some proportion to the forced inactivity. A small amount of routine physical exercise will be taken by the patient but the incentive for regular performance will diminish unless much personal attention is exhibited or unless the patient is unusually receptive to the rationale of bed activity

Bed rest for the average person is the signal for much boredom. In the period before confinement the mind is usually occupied by activities which are related to the erect position Further, the ability to move about continually opens new possibilities for mental diversion. The bedridden patient is thus confronted suddenly with marked diminution in muscular and mental activity which may become progressive. The tone (in the classic sense) of the muscle and the mind diminishes, and occupational therapy should be prescribed to maintain the desirable level of muscle and mental tone by individualized designation of occupations which will prevent

regression in morale or physical activeness. We have called this form of occupational therapy tonic.

Psychiatric

The label psychiatric is applied to those patients who cannot adjust to the community. The primary aim of psychiatric occupational therapy is to increase the adjustment potential or, at least, to prevent its further regression. Improved socialization is the primary aim but there are many symptoms of psychiatric disease which can frequently be favorably influenced by the intelligent prescription of occupational therapy.

If psychomotor activity has been depressed. it is possible to improve it by arousing the interest of the patient in a new or old activity The method by which this may be effected depends, to a great extent, upon the personality of the therapist and the choice of activity in the most deteriorated patients, there may be found, by perseverance and trial, some art form or occupation in which he can become interested and when this is discovered, a great step forward in his improvement has been accomplished. Most regressed patients who are brought to the occupational therapy department or to the play group will eventually participate if the approach is satisfactory, and success is partially dependent upon the personality and wisdom of the occupational therapist If the activity is of sufficient interest, its prolongation may improve concen-Discovery of the best form of activity is still a matter of try and try again.

For those patients who have a surplus of energy which is manifested by unsocial release, occupational therapy offers the opportunity of productive or guided expenditure. A patient who is assigned to metal hammering can bang his way to satisfaction and at the same time produce an object which may interest him method of guided energy release employs no tools Swimming or water sports may lead to the restfulness of fatigue resulting from thrashing about in the water for about an hour water is warm, sedation is usually more rapid It has been found that on disturbed wards where patients have exhibited destructive tendencies. the amount of linen and furniture destroyed, following the introduction of occupation therapy is markedly curtailed Occupational therapy offers an outlet for aggression, and should be prescribed for it.

Certain art forms can stabilize the emotions with resultant contentment, but even more apparent is the effect of art forms on mood Music is probably the form most frequently employed to affect mood. It has been found that most people prefer to listen to music which cor-

responds to their mood of the moment ⁴ The markedly depressed patient who listens to gay music may find his depressed mood accentuated by the contrast, and gay music should not be prescribed for such patients

For the severely deteriorated patient, great advantages in hospital discipline and morale may be gained from improving those habits of community life which are basic to social relations, such as orderliness, punctuality, and cleanliness. This form of occupational treatment, which has been called habit training, is best prescribed for small groups of patients, i.e., from 6 to 10 patients, as part of the "total push" program. 5 6

Occupational therapy can also be used to influence abnormal mental content. A patient with a guilt complex may find expiation in menial tasks. Frequently, after such patients are assigned to janitorial work, they give evidence of having satisfied this want. An interesting approach toward the crowding out of delusions is the use of pattern weaving. It is felt by some that a patient weaving an intricate pattern on a loom will concentrate so intensely on following the pattern closely that his mind will be too occupied to entertain delusions simultaneously

By the timely prescription of appropriate occupations, the physician can improve the patient's attitude The pleasure derived from work stems not only from the satisfaction of work appetite but from the quality and quantity A patient who has never learned to achieved play a musical instrument will gain confidence in proportion to the acquisition of musical skill If improvement eventually qualifies him for a place in the hospital band, the applause of his performance by the audience will increase his self-respect and this may lead to the development of better self-control The instrument selected must be within the range of the patient's ability, and during the training period it is important that criticism be friendly and commendation frequent By such methods occupational therapy provides an obtainable objective and gratifies narcissism

The physician must review the previous occupations and avocations of the patient before he prescribes an activity. There are some patients who may react favorably to the resumption of a previously acquired skill, and there are others who may not. Mental disease may be related to previous employment, in fact, it may have begun because of an inadequate voca-

tional situation, such as is found in the competition or personalities of fellow workers. Resumption of identical or similar operations may be followed by regression, especially if the mental aberration is intimately associated by the patient with his former work. Mental disease may also be related to tools or implements by which the patient was hurt or with which he harmed others

The mactivity which frequently accompanies the onset of mental illness may be followed by a diminution in the level of skill previously acquired A work assignment calling for that skill may accentuate the patient's depression or anxiety if the achievement does not reach previous attainment, whether the cause be physical, mental, or the lack of practice. Only if the physician is certain that there has been no reduction in skill or relationship to illness, should he prescribe a previously gained skill for the first project. For most patients the initial assignment should be in a field with which they are unfamiliar, after the patient has been properly evaluated he may resume a former vocation.

Occupational therapy can be used as a form of preventive medicine and, in fact, that is its most widespread application at present in noncommercial settings are almost invariably referred to as hobbies, and the mental hygienic virtues of hobbies are well known, or at least, well publicized Patients who suffer from boredom do not necessarily become mentally diseased if desuetude continues. Many will adjust to the mactive life with no other effect than intellec-Diversional occupation for the tual dulling bedridden is, thus, not always preventive, let alone therapeutic, and much that is called occupational therapy would be more properly labeled occupational diversion But the neurotic or tense patient may find therapeutic relaxation in mental and physical occupation, and the prescription of hobbies in the hospital, home, or community is an antineurotic

An attempt has been made in this paper to impress the physical medicine specialist with his obligations in the specific prescription of occupational therapy

30 HILLSIDE AVENUE

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Case Reports

SICKLE CELL ANEMIA WITH TYPHOID FEVER AND MILITIPLE COMPLICATIONS

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(From the Medical Service of Harlem Hospital)

SICKLE cell anemia is a hereditary and familial form of chronic hemolytic anemia which, as has been pointed out recently is apparently the only known disease that is confined to a single race. The ovidence is convincing that it does not occur except in the presence of Negro blood, even in extreme dilution.

Individuals affected with the disease are in a con stantly fluctuating state of anemia and jaundica. Frequently these patients exhibit a characteristic asthenic habitus.2 They may be tall and thin with long extremities, elongated digits, narrow hips, and narrow shoulders. The appearance is strikingly similar to the hypogonadal type of individual Chronic leg ulcors over the internal or external malleoli are commonly found and not infrequently are the main complaint and the initial clue leading to the diagnosis.* Exacerbations and remissions occur at irregular intervals In the intervals between relapees, pallor dyspnea, fatigue and palpitation are the main symptoms usually noted often in only a minor degree. However there may be a sudden in crease in weakness and fatigability accompanied by signs of marked anemia and jaundice and evidence of blood destruction by hemolysis of erythrocytes.4 The bilirubin content of the blood is high but no bile appears in the urine although the latter may contain a large amount of urobilin and urobilinogen This indicates that the jaundice is hemolytic in type.

Examination during these episodes reveals pallor of the mucous membranes and palms of the hands and a greenist-yellow tint to the sclerae. The spleen is palpable in approximately 15-20 per tent of eases. Generalized lymphadenopathy and enlargement of the liver also may be found.

The blood picture will reveal a marked to severe anemia (1000 000 to 2000,000 red blood cells per cu mm.) In stained smears a few of the cells are clongated and narrow with rounded or pointed ends. Nucleated red blood cells, chiefly normoblasts, are found and in addition polychromatophilis, basophilic stippling, and occasional Howell Jowell bodies.

The diagnosis is not usually made on stained smears but by the characteristic phenomenon which occurs when a drop of blood diluted with a drop of saline (but preferably undiluted) is sealed under a cover all p and incubated at body temperature. In such preparations a few bizarro multipointed forms may be seen immediately but changes occur at a maximal rate in from two to six hours after the

blood is drawn. These changes result in the transformation of a certain percentage of the red cells (sometimes as high as 90 per cent) into the typical crescent shape or sickle form with clongated and pointed filaments. Leukocytosis is an almost con stant finding, becoming particularly marked during the phases of active blood destruction sometimes as high as 25 000 to 40,000 leukocytes per cu. mm.

In addition to straightforward hemolytic crises, frequent causes of hospitalization are the joint and abdominal crises which occur "1". These are also hemolytic crises in which joint and bone pains or abdominal pains are the outstanding manifestations. Despite the most excruenting and agonising type of arthralgin it is extremely rare to find any tenderness, swelling or redness of the joints. Lesser episodes of aching pain in the joints or elsewhere in the extremittes are often referred to as "rheumatism. Indeed in an undiagnosed case acute rheumatism is often results."

Sovere abdominal pain may be sudden in onset, sharp and stabbling in character, and may be referred to the opigastrium or to the right or left lower quadrants. ** Vomiting prostration and rigidity with rebound tenderness may so closely mimic an acute abdominal catastrophe that many patients have been explored with the expectation of finding a ruptured peptic ulcer intestinal obstruction ruptured appendix or some other surgical condition * The finest diagnostic acumen and judgment are needed to evaluate the findings in such a situation since it must be borne in mind that per sons with sickle cell anemia may also develop an acute abdominal condition at some time during their somewhat shortened span of life.

It is our purpose to report a case of sickle cells anemia which, in the course of a prolonged hospitalization for an intercurrent enteric infection was found to exhibit most of the typical features plus the usual and unusual complications of this most interesting disease.

Case Report

S C. a 24-year-old Negro woman, was admitted to Harlem Hospital on July 16 1946 with a history of 'upper respiratory infection for the preceding two weeks Four days before admission the patient had developed nausea and vomiting She took an ounce of castor oilland a bottle of citrate of magnesia, a sovere diarrhea with abdominal colle followed.

The patient was a known case of sickle cell anemia, having been diagnosed as such in 1938. In 1937

she had been hospitalized at Harlem Hospital for pneumonia complicated by empyema which was treated by surgical drainage. Again in February, 1946, she was admitted and treated for "pneumonia" Review of \rangle-ray films taken at that time reveals that the course was that of a slowly resolving pneumonia, highly suggestive, in retrospect, of a pulmonary infarction 18

Physical examination on admission revealed a long, thin, anxious young woman who appeared to be acutely ill. The temperature was 104 F. There was pallor of the mucous membranes, conjunctivae, and nail beds. The sclerae appeared interior Other positive physical findings were limited mainly to the abdomen which exhibited marked tenderness and rebound in all quadrants. A moderate amount of rectus rigidity also was present over the whole abdomen. A few moist rales were heard in the right lower chest anteriorly. Bilateral ulcerations just above the ankles on the medial aspect of the legs were noted.

Laboratory findings on admission were as follows 2 plus albuminuma, specific gravity of urine 1 012, blood chemistry-creatinine 1 3 mg per cent, urea nitrogen 21 mg per cent, sugar 68 mg per cent, blood type B, Rh positive \(\text{\$\text{\$\text{\$\text{\$\text{\$A\$}-rav}}}\) of the chest revealed an infiltration of the right lower lobe with interlobar pleural thickening \(\text{\$\set{\end{taburnters}}}}} \end{taburnter}}}}}}} \end{taburnter}}}} \]

The patient's temperature continued plateau-like around 104 F, and the diarrhea persisted Abdominal tenderness and rebound also persisted By the end of the second week in the hospital abdominal distention appeared A blood culture taken on the seventh hospital day was now reported positive for Eberthelia typhosus Blood cultures repeated on the tenth and eleventh days were also positive for the same organism confirming the diagnosis

Additional laboratory findings during the second week were as follows x-ray of the chest showed a bronchopneumonic infiltration in the right lower lobe with thickened pleura, cephalin flocculation was 3 plus in twenty-four hours, 4 plus in forty-eight hours, serum bilirubin, 23 mg per cent, alkaline phosphatase, 646 Bodansky units Hemogram showed red blood cells, 970,000 white blood cells 20,700 (undifferentiated), and hemoglobin, 30 per cent Some porkilocytosis and sickle cells were seen on the counting chamber Blood agglutinations taken at the end of the first week were positive for typhoid O in a dilution of 1 640 and for typhoid H in a dilution of 1 320 Blood agglutinations by the laboratory of the Health Department were positive for typhoid O in dilution of 1 180 and typhoid H in dilution of 1 160 Icterus index was 17 4, van den Bergh test showed a direct immediate reaction Stool culture was again negative.

The patient was given a 500-cc transfusion of whole blood. Shortly after completion of the transfusion, she developed a chill, and the temperature rose to 107 8 F She appeared to be desperately ill, and immediate antipyretic measures were instituted with good results. During the third week, the temperature began to spike daily from 101 to 104 F. The blood picture continued to show a marked state of anemia, although not so severe as previously, and a moderate leukocytosis (16,500). A sickling preparation at this time again confirmed the diagnosis of sickle cell anemia. Cultures of

the stool now became positive for E typhosa, urine culture was negative, and Department of Health agglutination tests were positive for typhoid O in dilution of 1 160 and typhoid H in dilution of 1 80

She was given several small transfusions without reaction and now began to improve — Despite the improvement in general appearance, the temperature continued to rise daily up to 103 and 105 F. During the early part of the fifth week of hospitalization the fever suddenly subsided—Stool cultures were consistently positive for E typhosa, but the blood cultures, which had become negative in the third week, remained negative—She appeared to be much improved and entering a convalescent stage

In the sixth week the patient developed a painful swelling of the ulnar surface of the right forearm and a mild temperature elevation X-rays of the involved area revealed an irregular rarefaction of the midportions of the radius and ulna which had not been present one month before The opinion of the orthopedic consultant was "typhoid abscess with low grade infection of bone" His recommendation was "conservative management, as many so-called typhoid bone abscesses resolve spontane-ously" During the seventh, eighth, and ninth Fluctuation of the right forearm eventuated. The abscess was aspirated and 3 cc of a sanguinopurulent Cultures of the aspirated material obtained material grew no organisms. Repeated v-ray examinations revealed "moth-eaten rarefaction involving the middle two thirds of the radius and ulna with the development of a periostitis" Reexamination of the chest showed a decrease in the amount of infiltration in the right and left lower lung fields Stool cultures were still positive for E typhosa. Recheck of the blood picture revealed 1,920,000 red blood cells, hemoglobin 42 per cent, 18,750 white blood cells with 84 per cent polymorphonuclears.

The temperature now became normal, and the patient appeared well and definitely on the road to recovery this time. However, repeated cultures of the stool remained consistently and persistently positive. Sulfathalidine was administered, without effect on the typhoid organisms thriving in the gastrointestinal tract. In the fifteenth week a tube was carefully passed into the duodenum, and 20 cc of 25 per cent magnesium sulfate were instilled. A quantity of clear, yellow fluid, apparently bile, was obtained under sterile conditions. Cultures of this material grew E typhosa and a Streptococcus nonhemolyticus.

For the next two months, the fourth and fifth of hospitalization, the patient remained afebrile, well, and in isolation, stool cultures, of course, remained positive.

During the night of December 14, in the sixth hospital month, the patient developed excruciating, colicky, lower abdominal pains. Somewhat similar but milder attacks had occurred in childhood and on admission to the hospital this time. Examination of the abdomen revealed extremely marked tenderness to palpation over-all with intense rebound tenderness. The signs appeared to be maximal in the left lower quadrant. Voluntary rigidity was also present over the entire abdomen. Rectal examination revealed pain on manipulation of the cervix, with no lateral wall tenderness. Vaginal examination revealed normal adnexae and again marked pain on manipulation of the cervix. The temperature rose to 101 F, and examination of the peripheral blood showed 2,800,000 red blood cells,

hemoglobin 58 per cent, 37 750 white blood cells with 89 per cent polymorphonuclears. Typical sickling of the red cells was seen on the counting chamber and in the stained smear about 10 to 20 per cent of the red blood cells were estimated as exhibiting the sickling phenomenon Surgical consultation advised immediate laparotomy for an acute condi-tion, possibly a rupture viscus. The medical serv ice maintained the opinion that the episode was an abdominal crisis of sickle cell anemia simulating a surgical emergency and thereupon instituted a period of close observation and watchful waiting In the next twenty four hours slight improvement was noted following a transfusion of 500 cc. of whole blood. The patient now appeared to be fairly comfortable while not being examined. No nauses vomiting or distention appeared and the temperature remained low At the end of twenty four hours, maximum tenderness shifted over to the right para-umbilical region and the temperature rose to 102 F Still no distention or vomiting was At this time it was decided to perform an ex ploratory laparotomy

The findings at operation were as follows small quantity of clear yellow fluid was found in the general peritoneal cavity with a larger amount in the pelvic cavity (total about 500 cc.) The visceral peritoneum was shiny and glustening with no evidence of peritonitis. Scattered petechial hemorrhages or small infarcts were noted along the mesenteric attachment of the small intestine fluid was seen in the lumen of the small bowel which appeared to be blood-tinged In the right upper quadrant there were numerous adhesions of the omentum to the liver gallbladder and transverse The gallbladder was thirkened contracted and intrahepatic in position. Before the gallblad der was opened about 5 cc of a scrosangulnous ma terial was aspirated When cholecystostomy was performed about 200 black stones were found and removed. These stones ranged in size from pinhead to 1/2 cm. or more in diameter Cultures of fluid from the upper and lower abdomen and the gall-bladder were found to be positive for E. typhosa.

The postoperative course was uneventful and uncomplicated except for marked jaundice immediately after operation in which the ictorus index rose to 150 van den Bergh test was direct, immediate serum bilirubin was 54 mg. per cent and thymol turbidity, 5 Bile drained freely and abundantly turbidity, 5 Blie drained freely and anunuantly through the T tube which had been autured into the gallbladder Stool cultures still remained positive, and of February 15 1947 the patient was discharged under the surveillance of the Department of Health. She was instructed to return in two to three months

for a cholecystectomy

Comment

This case is reported as one of mckle cell anemia complicated by typhoid fever acute hemolytic erises probable pulmonary infarction due to capillary plugging by sickle-shaped red cells typhoid abseess and periostitis of bone a typhoid carrier state chronic cholecustitis and cholelithiasis secondary to sickle cell anemia,* and a severe abdominal crisis of sickle cell anemia simulating an acute abdominat condition This last diagnosis is believed to have been established not only because the opera tive findings did not explain the sevents of the abdominal signs and symptoms, but also because in the immediate postoperative period, extreme jaundice appeared while drainage of blie proceeded freely and abundantly. It is obvious that in this case the leterus was due to excessive bemoly sus of red blood cells.

Summary

- A case is reported which illustrates almost all the known clinical features and complications of this most unusual form of the chronic hemolytic anomias.
- The gallbladder is again demonstrated as the visceral harbor for the typhoid organism in a chronic carrier state
- 3 Acute hemolytic crises and abdominal crises of mckle cell anemia are very often precipitated by high fever and toxicity in this case the precipitating disease was severe typhoid fever
- 4 Emphasis is placed on the necessity for extreme caution and judgment based on experience to determine when a patient with sickle cell anemia is suffering from an acute surgical abdomen. In the case reported here although operation revealed a chronic surgical condition of the gallbladder surcical interference should have been postponed until the abdominal crises of sickle cell anemia had sub-

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NEW LAW RELATING TO PUBLIC HEALTH

The New York State Legislature has enacted the following law of 1948 effective immediately

Chapter 179—Section 311-a a new section added the Public Health Law 1 robibits the use of to the Public Health Law vaccine for inducing immunity against tuberculoids in humans unless it is produced in accordance with the regulations established or approved by the State commissioner of health - It provides that vaccina tion against tuberculosis shall be performed only under regulations established by the commissioner

LIPOID NEPHROSIS WITH NECROPSY FINDINGS

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Lipoid nephrosis per se, although not a common disease, is seen frequently enough to warrant presentation for reasons other than its rarity. This case is presented because of the picture at the first admission to this hospital and the subsequent question of diagnosis. The diagnosis of acute and chronic glomerular nephritis with hopeless prognosis was made at other institutions. The patient's course and response to therapy bring the realization that one must sometimes adhere to a conviction and act accordingly.

The name, Diabetes albuminurica, given by Epstein, almost completely describes the disease—The pathology and physiopathology are mainly in the tubules—manifested as fatty degeneration—The urine shows marked albuminuria and waxy casts. Some observers claim that the presence of red blood cells does not rule out the diagnosis—The loss of the albumin causes a marked reduction in the total serum protein with a reversal of the albumin-globulin ratio—There is also an increase in cholesterol and a lowered basal metabolism, both indicating decreased metabolism

Whether or not the disturbance in metabolism is, as ordinarily considered, controlled by the pituitary-thyroid axis, or whether the disturbance is in the intrinsic metabolism of the tissue cells, particularly the lipoid metabolism, still remains to be answered Because of the interest in this controversial subject, this case report of a patient followed from the inception of the disease until her death is presented

Case Report

A 26-year-old Puerto Rican woman was admitted to the hospital March 15, 1935, with chief complaints of swelling of the face, pain in the back, a fourteen-month history of headaches, and swelling of ten months' duration of the "stomach," legs, hands, and body. The diagnosis was subacute diffuse glomerular nephritis with nephrosis and pneumococcus peritonitis, or lipoid nephrosis and pneumococcus peritonitis.

No dysuma or noctuma was experienced at any time. The urine varied in color from "red" to "vellon" but was never grossly bloody. At times micturition was only once in twenty-four hours. Past history was negative for scarlet fever, diph-

theria, and tonsilitis

Thirteen months previously, the patient had been at Bellevue Hospital for six weeks where the diagnosis was chronic glomerular nephritis with specific gravity of 1 022, albuminum, and red blood cells.

Basal metabolism was minus 6 4 per cent
Following discharge from Bellevue, she was hospitalized at Post-Graduate Hospital for six weeks, the diagnosis being chronic glomerular nephritis and acute pharyngitis Therapy consisted of a high protein diet for the edema X-ray of the gastromtestinal tract was negative X-ray of lumbar spine disclosed hyperostosis of the fifth lumbar vertebra. The patient signed out against advice and was admitted to St. Vincent's Hospital for generalized edema. The findings were as follows reversal of the albumin-globulin ratio, marked increase in cholestrol, and marked albuminum with a

moderate number of red blood cells Basal metabolism was minus 5 per cent, nonprotein nitrogen on admission was 33 3 per cent, on discharge 42 8 per cent. The patient signed herself out after six weeks Following discharge from Post-Graduate Hospital, this edema fluctuated, and the patient stated that whenever she went on a high meat diet, as recommended by the hospitals, her "stomach" swelled On a meat-free, salt-free diet this did not occur

The patient was admitted to the Hospital for Joint Diseases because of the persistent edema Laboratory data and findings were as follows—urne on admission showed a 4 plus albumin, few red blood cells, no casts, and a specific gravity of 1 022—Concentration tests showed variations from 1 003 to 1 018—Stools showed no ova or parasites—Basal metabolism was minus 20 per cent, hemoglobin 75 per cent—Red blood cells numbered 4,300,000, white blood cells 11,000, and the differential count was normal except for 5 per cent eosinophilia—Sedimentation rate was 83 mm, our normal being 8 mm, in 45 minutes—Serology was negative—The blood chemistry analysis showed urea nitrogen 7 9, creatinine 1 3, sugar 85, uric acid 1 6, cholesterol 620, calcium 9 1, and phosphorus 5 7—The serum protein was a total of 3 73, the serum albumin 0 75, serum globulin—2 98, with an albumin-globulin ratio of 0 25

On admission weight was 95 pounds The patient was placed on a high protein, low salt diet, and visible edema increased, despite the fact that the patient was receiving regularly as much as 200 Gm.

of protein a day

Five weeks after admission, the patient developed a spontaneous diarrhea. Laboratory findings at that time were eosinophilia 7 per cent, with a 9,000 white blood cell count. Sedimentation rate 90 mm in 45 minutes. Blood chemistry was essentially unchanged, showing again total protein of 3 3 Gm, serum albumin of 0 70 per cent, and serum globulin of 2 6 with an albumin-globulin ratio of 0 27. A basal metabolism test was not repeated at this time. Urine still showed 4 plus albumin, hyalin and granular casts, and occasional red blood cells.

Six weeks following admission, the patient was given 4 mg of thyroxin intravenously, after which there was a slight drop in the patient's weight and a general clinical improvement. Two days after the administration of thyroxin, the patient developed a temperature of 102 F, chilly sensations, and severe pain in the abdomen. She had two loose bowel movements containing blood. The impression was that she had developed a pneumococcus peritonitis. She was treated conservatively, and temperature

and pain subsided

Eleven days after the first administration of thyroun, the patient was given 5 mg intravenously. The patient became brighter, her appetite improved and diuresis occurred with subsidence of the edema. Urine was essentially unchanged Cholesterol dropped to 600. One week later, she received another dose of 5 mg of thyroun, followed by a marked diuresis and drop in weight from 100 pounds to 88 pounds. Most of the visible edema disappeared. There was a complete change in the personality of the patient from that of a morose and uncooperative individual to a cheerful and smiling one. Cholesterol, one week later, showed an increase, and the patient received 7 mg of thyroun intravenously.

This time the response was not marked, and the edema increased. The patient received 11 mg of thyroxin but the edema increased so that five days later, she received 15 mg of thyroxin intravenously, without marked response. She became ill and vomited. The question of developing uremia arose,

Findings at this time for the urine were as follows specific gravity varying from 1 010 to 1 028 4 plus ablumin and sediment of occasional red blood cells, few white blood cells and no casts. The blood chemistry showed urea nitrogen 24 4 creatinine 2 2 sugar 79 uric acid 6.2 carbon dioxide combining power 31.5 Basal metabolism was plus 2 per cent. Patient's vomiting was controlled by 5 per cent glu-

cose clyals.

Five days later the patient became more cheerful brighter, and the blood chemistry showed urea ni trogen of 22 creatinine 15 sugar 70 and urie acid 55. The patient received no more thyroxin and continued to lose weight. The decima completely subsided, so that at the time of discharge patient's weight was 89 pounds. The final urines still showed good concentration having specific gravity from 1015 to 1022, the amount of albumin varying from negative to faint trace, and only on one occasion a 4 plus albumin. The final blood chemistry showed a urea nitrogen of 70, creatinine 14 sugar 85 uries acid 36 cholesterol 460 cholesterol caters 298, total protein 4 serum albumin 090 serum globulin 2.01 and albumin-globulin ratio 034 Electroardiogram was negative. The patient continued to improve and was discharged without any visible edema having received a total of 47 mg, of thyroxin

Since discharge the patient was lost sight of until February 1038 The patient and her husband claim she was apparently well in the interim. On February 16 1038 she was admitted to Miscricordia Hospital complaining of pain in the left cheet on respiration. Examination revealed a consolidating pneumonia in the left lower lobe a pregnancy of surmonths temperature of 103 F with a white blood cell count of 21 000 with 90 per cent polymorphonuclears. Urne examination revealed a specific gravity of 1.020 with a faint trace of albumin. The patient developed an empyrema and a rib resection was done on March 8, 1938. The patient did well having some prolonged intercostal drainage. Labor atory data April 1938 follows specific gravity of the urine varying from 1 010 to 1026 in casual specimens, albumin from a faint trace to none. Hemoglobin 77 per cent with 4 000 000 red 128.7 creating 1.10 to 1, 100 to 1

On April 16 1938, the patient was seven and one-half months pregnant and felt well. There had been no headachee nocturia or gross abnormal urinary find ings since her discharge. Her general appearance was good head and nock were negative and the chest had a draining intercostal wound on the left posterior side. Blood pressure was 116/78. There was a slight lordosis and no edemà. The abdomen presented symmetrical swelling due to the pregnancy

Laboratory findings showed specific gravity varied from 1010 to 1020 a faint trace of albumin negative glucose, negative microecopic findings in the wine concentration test. Results of the blood count were 120 Gm. hemoglobin 4 160 000 red blood cells, 10 200 white blood cells, 48 per cent polymor phonuclears, 48 per cent lymphocytes 1 per cent monocytes 2 per cent codinghis, 1 per cent stabs. Blood chemistry showed glucose 80 nonprotein

nitrogen 10 uric acid 31 sorum proteins 70 per cent albumin 30 per cent globulin 87 per cent, albumin globulin ratio 105 cholesterol 302 Basal motabolism nlus 14 per cent.

Toward the end of her pregnancy the patient doveloped mild hypertension and headaches and was diagnosed as having a mild tovemia of pregnancy She was delivered by cesarean section made an un eventful recovery and was well until her second ad mission to the Hospital for Joint Diseases on October 8 1938 At this time she complained of increasing generalized edema and vague joint pains Tem perature on admission was normal but rose to 102 5 F on the third day Examination revealed blood pressure 132/94, heart enlarged slightly to the left and A₁ slightly accentuated. There was an impaired percussion note and diminished breath sounds at the left base. Examination of the abdomen revealed the presence of ascites Bronchopneumonia was diagnosed and on bed rest and a high protein diet, the patient recovered from this acute illness and the urinary findings detailed below cleared Urine random specimens showed specific gravity varying from 1015 to 1031 albumin 4 plus oc ensional white and red blood cells and inconstant findings of an occasional hyalin or granular cast, Wassermann was negative On October 11 1938 her total serum protein was 3 3 Gm per cent sedi mentation rate was 86 mm, in 45 mmutes. On November 3 her total protein was 5 4 Gm. per cent and her seximentation rate was 30 mm. in 45 minutes. It was felt that the elevated sedimentation rate was due to the hypoproteinemia which dropped with a rise in the total blood protein. At no time did she show any evidence of anemia Her total cholesterol was 620 and cholesterol esters 514 The impression was that as a result of her recent pregnancy the nephrotic picture became aggravated

The patient then developed an acute infection with fever which resulted in a gradual and complete subsidence of the edoma with maintenance of good urine specific gravity and gradual diminution in the protein content of the urine The patient was discharged on November 10 1038

On October 24 1039 the patient was admitted for a third time because of generalized joint pains in creasing edema, and a weight gain of 11 pounds starting about three months before admission She also complained of dull headaches and occasional at tacks of pain in the right flank. Examination revealed edema of the scalp face legs ankles and presacral areas. There was no cyanosis dyspnes or orthopnes. The heart and lungs were essentially orthopnes. The neart and langs note Examinegative and blood pressure was 120/75. Examination of the abdomen revealed ascites. Irver and spleen were not felt. The specific gravity of the urine varied from 1 005 to 1 025 and albumin from 1 to 4 plus. A moderate number of white and red blood cells were found varying in each specimen. rare hyalin and granular cost was occasionally present. Phenolsulfonphthalein concentration test results were 45 per cent first hour 17 per cent second hour 17 per cent third hour 7 per cent fourth hour giving a total of 76 per cent excretion which is in the normal range. The basal metabolism rate was minus
15 per cent Kahn and Klein tests were negative. Hemoglobin was 14 4 Gm. red blood cell count was 4 640 000 and the white blood cell count 7 000 with a normal differential count. The sedimentation rate was 67 mm, in 45 minutes Chemistry showed sugar 80 mg. per cent, nonprotein nitrogen 23 mg. per cent, cholesterol 545 mg per cent, cholesterol esters 370 mg. per cent, total proteins 2.3 Gm per

cent. albumin 12 Gm per cent, globulin 11 Gm per cent with an albumin-globulin ratio of 1 05, and

chlorides 650 mg per cent.

The Congo red test showed a disappearance of 50 per cent of the dye in one hour, a small amount being present in the urine. The electrocardiogram was negative. The patient was placed on a high protein diet and flind limited to 1,200 cc daily. She was started on 5 mg intravenous thyroxin. Under this started on 5 mg intravenous thyroun Under this treatment she felt stronger, but her cholesterol rose to 759 mg per cent The serum albumin remained at 12 Gm per cent, but the globulin rose to 18 per cent, and the albumin-globulin ratio fell to 0.7 per cent. She complained of frequent attacks of unexplained pain in the right side of the abdomen and At times she was quite psychotic December 20, she complained of a severe toothache for which no therapy was instituted Early the next morning she had a chill with a rise in temperature to 102 6 F and complained of severe pain in her right Examination revealed tenderness in the right vertebral area The urine was not grossly costa vertebral area

A flat plate of the abdomen revealed a moderate dilatation of small intestinal loops and of a portion of the transverse colon A blood culture was positive for hemolytic streptococcus in twenty-four hours The next day the temperature rose to 104 4 F, and the pulse became weak and thready The abdomen became distended, and there was rigidity and tenderness in the right upper quadrant The temperature rose progressively to 1052 F, and the patient died In consideration of the confusing picture, particu-

larly regarding the kidney condition the following abstract from the official autopsy report is of marked Anatomic diagnosis (1) Lipoid nephrosis (2) streptococcus hemolyticus bacteremia, (3) infected ascites and right hydrothorax, (4) edema of the lower extremities, (5) endocrine imbalance with atrophy of the ovaries, persistent thymus, and small thyroid and parathyroid glands, (6) subacute and chronic pleuritis, and (7) cholesterosis of the aorta

The following are the chief pathologic findings Abdominal cavity showed several liters of turbid chylous-looking fluid and fibrin, a smear of which showed the presence of hemolytic streptococcus and Bacterium coli The impression was one of an in-

fected ascites

Pleural cavity the lower left pleural cavity was obliterated by fibrous adhesions, and the base of left lower lobe was adherent to the diaphragm The right lobe showed the presence of several hundred cubic centimeters of slightly turbid fluid Lungs showed the presence of diffuse bronchopneumatic process Heart—there was a small amount of clear fluid in the pericardial sac There was no hypertrophy in any of the ventricles, auricles showed bright yellow subintumal cholesterol streaking in the ascending and descending portions, liver was slightly en-larged, smooth and soft, and yellowish-brown in ap-The lobular architecture was visible pearance Microscopic section showed fatty changes and some parenchymatous degeneration

Kidneys-both kidneys were slightly enlarged The capsule stripped with ease, exposing a smooth, strikingly yellow surface. The vessels were constrikingly yellow surface The vess gested, but no hemorrhages were seen The kidneys were soft in consistency Both the surface and cut sections presented extensive evidence of lipoid deposition in the form of bright yellow specks and The markings of the cortex and medulla differentiated The appearance of the kidstreaks could be differentiated neys was that of either a genuine lipoid nephrosis or a nephrotic phase of glomerular nephritis A frozen section of the kidneys stained with Sudan red revealed the extensive deposition of fat-staining droplets and globules, principally in the epithelium of the convoluted tubules

Microscopic section of the kidney showed no evidence of acute or subacute glomerular nephritis There were, to be sure, scattered foci of mononuclear cells, principally beneath the capsule and along the course of the blood vessels, and there also was slight desquamation of tubular and glomerular epithelium These changes, however, may be reasonably attributed to the terminal streptococcus bacteremia the many kidney sections examined, only a very occasional glomerulus was found partially or com-pletely obliterated, not more than 2 per section as an average Even these may conceivably be related to the episode of the toxemia of pregnancy with a tem-Furthermore, Mallory stains porary hypertension did not disclose any appreciable thickening of the basement membrane of the glomerular tufts or cap-The more striking feature, of course, is the extensive deposition of lipoid in the kidneys within the tubular epithelium, as collections of foam cells between the tubules, and even within some of the glomerular tufts

Conclusion

This case report is presented because of its varied clinical picture, because of the widely different diagnoses made at other institutions, and because of the variety of opinions expressed by members of the medical staff of the Hospital for Joint Diseases during her three admissions

The case may be considered as one of pure nephrosis followed for four years through a variety of clinical syndromes, including pneumococcic peritonitis, pregnancy terminated by cesarean section, pneumonia complicated by empyema, necessitating rib resection, and streptococcus hemolyticus peritonitis

and bacteremia terminating in death

The apparent response to thyroxin therapy on the patient's first admission, the subsequent clinical course with few if any renal symptoms, the laboratory findings such as hypoproteinemia with inversion of the albumin-globulin ratio, the low metabolism rate and high cholesterol, and the absence of any real clinical or laboratory evidence of nephritis, e g the absence of azotemia, a good phenolsulfonphthalein function test, good concentration of urine, and microscopic urinary findings which cleared whenever the patient's acute illness cleared, all point away from the diagnosis of glomerular nephritis and point toward a diagnosis of lipoid nephrosis conclusions all seem to be borne out by the gross and microscopic findings in the kidneys of the patient at postmortem examination

2021 GRAND CONCOURSE

CONGENITAL THIAMIN DEFICIENCY

LOUIS S GOLDSTEIN, M.D., Yonkers, New York

(From the 1 onkers Professional Hospital and 1 anderbilt Clinic New York City)

CONGENITAL thiamin deficiency (congenital beriberi) is not as rare as we are inclined to believe. Acute severe thiamin deficiency is not readily recognized because of the age period at which it appears, because of the high mortality and because of the absence of pathognomonic postmortem findings.

In view of the scarcity of reports on congenital thiamin deficiency in occidental literature the following case will be described in detail. It is intended to illuminate the symptomatology and also to deduce facts which may help to explain dehydration fever in the newborn.

Case Report

Case 1—A 27 year-old primiparn who had had an operation for toxic goiter four years previously complained of a very disagreeable pregnancy. For the first four months she suffered with morning names and vomited at least once daily. Hearthurn was a recurrent complaint. She experienced pain in the right leg from the knee to the ankle but at no time were there paresthesias of the hands or feet. Knee jerks were absent. When six months' present, her face and legs became swollen, although her blood pressure remained normal (120/80 to 180/80), and her urine did not contain albumin. She gained 20 pounds. One week before delivery she developed a mark ed loss of appetite particularly for meat. The diet consisted of corn flakes, rice, orange juice, grapefruit juice, tomato juice bananas cheese and cream, one glass of milk daily an egg every second or third and a mixed vegetable salad in the evening. Throughout her pregnancy she received 16 mg, of thiamine hydrochlonde, three liver and iron capsules daily plus calcium and vitamin

A girl was born one month prematurely on April 24 1947, weight was 2 600 Gm. She was admitted to the nursery apparently in good condition. That afternoon the attending pediatrician reported the infant a normal eight-month prematurely born infant with no conganital anomalies or deformities However, twenty-seven hours after birth at 6 20 AM the following morning April 25 1947 the infant suddenly became evanotic and experienced difficulty

in breathing. She accordingly was placed in an incubator with added oxygen

The temperature was 101 F by rectum. Respirations were labored and rapid and became more so when the infant cried. The body was held quite rigid. From time to time, a coarse bilateral tremor of the arms appeared. The cry was low and plaintive. The color of the torso was a faint pink. There was no evidence of dehydration of the torso or arms. However, conspicuous was a brawny pitting indumtion and edema of the legs from the hips to the ankles. Thoskin, here, was slightly discolored a grayish-blue. There were no naovi. The fontanelles were not bulging. The ears, nose and throat appeared normal. The tongue was a bit more red at the tip than is normal. The heart was so rapid that the apax beat could not be counted. The area of cardiac dullnoss was not increased to percussion. No murmurs were heard. The lungs were clear. Liver and spleen were not enlarged. The umbilical stump appeared normal. Aniss was normally patent. The knee jerks were abeent. Bieeps reflexes were equal and active.

Treatment —Dail; injections of ½ cc. of Botalin Complex (Lilly's Vitsmin B Complex) were given intramuscularly Two milligrams of 8ynkamin (Parke Davis and Company's Vitamin K) were also injected intramuscularly at once. The formula consisted of 5 ounces of evaporated milk, 16 ounces of botled water 1 tablespoon of granulated sugar and 1 teaspoon of Dayamin (a multivitamin syrup prepared by Abbott) Three ounces were offered at three-bour intervals.

Chucal Course.—At midnight, April 25 1947 roctal temperature was 104.2 F Thereupon a change for the better began to take place. Respirations became more regular and less rapid. The cyanosis disappeared. The child cried less frequently and the

became more regular and less rapid. The cyanosis disappeared. The child cried less frequently and the cry was much stronger but obviously hoarse. The tremors of the arms ceased. The infant was able to suck on the nipple and took 1½ ounces of the formula. The edema of the legs diminished. By 8-00 A.M., April 26 1947 the temperature had dropped to 90 F by rectum and continued so throughout the remainder of the hospital stay. There was considerably less edoma of the legs and

TABLE 1 - LABORATORY DATA

[ADDE 1 March 100 A							
liemogiabin, Gra. Red blood cells	April 26 16 65 5 100,000	April 28 17 8 5 360,000	May 3	May 5	May 6		
Color index White blood cells Per cent polymorpho u lears Per cent atab forms	0 00 47 500 61 21	38,200 25 20	48,800 16 *3		25,550 47 17		
Per cent juveniles Per cent myelocytes Per cent promyelocytes Per cent lymphosytes	12	12 11	10 27 12 8		36 (Some lymphocytes were stypical)		
l cent monocytes Per cent cosinophils Bleeding time, minutes		1	3		were mrypromi)		
Congulating time minutes Platelets Turio grasules		60,400 Plus	1"3,400 Plus	209 000			

thighs The skin could be picked up between the two examining fingers. The baby was now taking

11/2 to 2 ounces of formula every three hours
On the third day, April 27, 1947, there was
physiologic jaundice She ate vigorously, taking 2 ounces at each feeding. She slept between feedings and very rarely cried Color and turgor were normal There was no peripheral edema and no obvious weight loss

On the fifth day, April 29, 1947, the formula was increased to 6 ounces of evaporated milk, 12 ounces of boiled water. 2 tablespoons of granulated sugar, and I teaspoon of Dayamin She consistently finished 2 ounces at four-hour intervals At two months she weighed approximately 5,000 Gm. There was slight head lag but no sag Social smiling was apparent

Comment

It is difficult to establish a diagnosis of thiamin deficiency by means of laboratory tests unless a specialized laboratory is available Clinical signs, however, pointed to such a diagnosis, and the rapid response to vitamin B therapy substantiated it Since specific thiamin deficiency does not produce edema, the entire vitamin B complex was used for Within twelve hours, the infant began treatment to show clinical improvement Respirations became more regular and less rapid, she cried with a stronger, hoarse voice She had sufficient strength to suck the nipple and take her formula temperature began to drop, and at 8.00 A.M., the following morning, it was 99 F by rectum, continuing normal for the remainder of her hospital stay Simultaneously, most of the edema of the lower extremities disappeared

It was a great surprise, however, to find that, in spite of the disappearance of the edema, the weight This demonstrated concluremained stationary sively that there was a simple transfer of fluid from intracellular to extracellular spaces The peripheral edema merely removed intracellular and circulatory fluid, and this produced anhydremia with its concomitant syndrome of peripheral circulatory collapse

Usually for the first twelve hours after birth, the infant receives nothing by mouth Thereafter, 5 per cent glucose solution is offered until the breast milk appears or artificial feeding is introduced creates spontaneously two conditions with which to cope, namely, the heightened metabolism of the newborn and the increased consumption of thiamin (a cocarboxylase or catalytic agent) for thorough metabolism of carbohydrates Both are conducive to rapid diminution of the limited retention supply of thiamin This predisposes to symptoms of minimal thiamin deficiency (dehydration fever) or precipitate signs of acute severe congenital thiamin deficiency

Summary

A case of acute severe congenital thiamin deficiency (congenital beriberi) with dramatic response to vitamin B complex is described

It is suggested that dehydration fever of the newborn is a clinical manifestation of thiamin deficiency

189 VALENTINE LANE

SKIN ERUPTIONS OFTEN DEVELOP FROM DRUG APPLICATIONS

Skin eruptions often are caused by drugs used to correct an existing disorder, according to an article by Dr Lester Hollander, Pittsburgh, in the current 1880e of Hygera, the health magazine of the A.M A.

"It is common knowledge among skin specialists," Dr Hollander asserts, "that both externally applied and internally administered drugs can cause a

great variety of skin eruptions
"Since the actual cause of an eruption is increasingly more difficult to identify as its duration lengthens, and since certain cruptions may precipitate chronic organic damage, physicians have to be on the alert for them However, most of the annoying skin eruptions of this class are not caused by pro-fessionally prescribed medication. The source of fessionally prescribed medication a blistery eruption of the hands and feet or a diabolic nocturnal itch is more often found in the consumption of proprietary [patent] medicines"

Cold remedies, headache cure-alls, and cathartics are among the most common remedies causing

skin disorders, the doctor states "The kingpin among the many-purposed vitamin B complex groups, thismine chloride or B₁, not infrequently causes a skin eruption. At times the

benefits of vitamin B are nullified by the inconvenience, insomnia, and nervousness caused by the

"You can accept it as axiomatic," the article continues, "that any skin disease or eruption which becomes increasingly annoying after the use of a local application is being irritated and not helped by it—even if its 'purity' and 'nonirritating' qualities are certified by movie stars, golf professionals, or any such disinterested, self-sacrificing people. all these nostrums the so-called athlete's foot remedies are the most noxious

ADDITIONAL ANNUAL REPORT

MEDICAL SOCIETY OF THE STATE OF NEW YORK

1947-1948

Report of the Treasurer

To the House of Delegates Gentlemen

The financial status of the Society is shown in the accompanying letter of transmittal and excerpts taken from the report of our auditors the firm of Patterson and Ridgway, certified public account-ants, who examined the books of the Society for the fiscal year 1947

Last year in the report of the Treasurer it was pointed out that we were operating in the red for the first time in many years The House of Delegates last year voted to increase the State assessment from \$10 to \$15 This was in May, 1947 but of course did not become operative until this year

(January 1 1948)
During the remainder of 1947 expenses of operation continued to increase There were still a great many members of the Society carried on our books whose dues were remitted because of military serv ice. Another factor was the necessity of moving the offices and enlarging their size. This latter item entailed a great deal of additional expense and an increased personnel. Therefore, toward the close of the year we found our bank balances were at a perilously low figure, and it became necessary for the Board of Trustees to authorize a loan in the amount of \$50,000, so that we might continue to pay our current bills.

During the course of the year our accounting system has been modernized and brought up to date in many respects. The work in the accounting department has increased because of payroll deductions for withholding tax, social security old age pension, and also the proper accounting check system, office

purchases, sales advertising, and so forth.

The Finance Committee has set up a budget which

The Finance Committee has set up a budget which shows an estimated surplus at the end of the ensuing fiscal year of \$38 302. It is to be noted, however that we start the year with a deficit of approximately \$50 000 chargeable against the preceding year, and it is going to be only by the closest application of economy that we may end up this year in a favorable position.

It is believed that, with increased membership the gradual ecostion of remuseous of dues and the

the gradual cessation of remissions of dues and the increase in the assessment, we will again be able to operate within our dues income. However this supposition is predicated on a stable economy. If rapidly rising costs should continue we may again find ourselves in the same position we were in last year when as an example, the cost of publishing the Directory exceeded the previously estimated cost by over 60 per cent.

In closing my report I should like to express my sincere thanks and appreciation to all members of the staff of the Medical Society of the State of New York for their helpfulness and cooperation during the past year I also wish to extend my deep personal gratitude to the Assistant Treasurer, Dr Fenwick Bockman, for his able and kind assistance on a number of occasions when it has been necessary for him to function.

> Respectfully submitted. JAMES R. REULING, M.D., Treasurer

March 11, 1948

Auditors Certificate

To the Board of Trustees Medical Society of the State of New 1 ork

We have examined the balance sheet of the Medical Society of the State of New York as of December 31 1947 and the statements of operating income, financial income and capital for the year then ended, have reviewed the system of internal control and the accounting procedures of the Society and, without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence, by methods and to the extent we deemed appropriate. Our examination was made in accordance with generally accepted auditing standards and included all procedures which we considered necessary in the circumstances.

We did not confirm the unpaid members' dues

by correspondence with the members.

In our opinion, the accompanying balance sheet and statements of operating income, financial in-come and capital present fairly the position of the Medical Society of the State of New York as at December 31 1947 and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year

> PATTERSON AND RIDGWAY Certified Public Accountants

Balance Sheet-December 31, 1947

ASSETS		
GENERAL FUND		
Current Assets Cash in banks and on hand Accounts Receivable Less Reserve for Doubtful Accounts and for Commissions	\$ 10,871 97 948 35	\$ 91,371 51 9,923 62
Advances to Veterans Medical Service Plan of New York, Inc Due from Endowment Fund Dues Receivable—Net, estimated Investments—		16,496 87 50 00 4,740 00
At Cost (Market or Redemption Value \$474,154 50) (see Notes A and B) Accrued Interest Receivable Inventory of Paper Stock		455,229 70 9,447 13 7,089 04
Other Assets		594,347 87
Advance Costs 1948 Medical Directory 1948 Annual Meeting Prepaid Expenses and Deposits	7,699 57 1,332 91 3,337 18	12,369 66
FURNITURE AND FIXTURES—At Nominal Value		2 00
ENDOWMENT FUNDS		
Cash in Bank		12,313 39
TOTAL ASSETS		\$ 619,032 92
LIABILITIES AND CAPITAL		
GENERAL FUND		
CURRENT LIABILITIES Bank Loan. (see Note A) Accounts Payable Commissions Payable—Journal and Directory Advertising Sales Taxes Payable	\$ 50,000 00 36,735 57 7,347 77 4,421 45	\$ 98,504 79
DEFERRED INCOME Prepaid JOURNAL Advertising and Circulation Annual Meeting—1948 Prepaid 1948 Membership Dues	1,685 22 14,482 50 4,270 00	20,437 72
Reserve for Future Annual Meetings		10,000 00
Capital—General Fund		477,777 02
ENDOWMENT FUNDS		
ACCOUNT PAYABLE	50 00	
Capital Lucien Howe Prize Fund Merritt H. Cash Prize Fund A. Walter Suiter Lectureship Fund	4,919 16 1,958 40 5,385 83	
TOTAL LIABILITIES AND CAPITAL		12,313 39 \$ 619,032 92

NOTE A U.S. Treasury bonds in the amount of \$101 000 00 (par) have been pledged as collateral on the bank loan NOTE B U.S. Treasury bonds in the amount of \$60 000 00 have been earmarked for the Journal Reserve and \$10 000 00 for the Annual Meeting Reserve.

OPERATING INCOME

CASH IN BANKS AND ON HAND DECEMBER 31, 1947

General Funds Investment Funds	\$ 63,680 66 27,690 85
TOTAL CASH	\$ 91,871 51
ENDOWMENT FUN	DS
Lucien Howe Prize Fund Vierritt H Cash Prize Fund A. Walter Suiter Lectureship Fund	Union Dime Savings Bank \$ 4 919 10 1 958 40 5 435 83
	\$ 12.813.89

STATEMENT OF OPERATING INCOME AND EXPENSES For the Year Ended December 31, 1947

OPERATING INCOME		
Mombers' Dues-1 ear 1947		₹ 184 120 00
Less Reserve		1 970 00
2000170		10,000
		182 150 00
Less Allocation to Journal Circulation Income as Authorized by the		
Board of Trustees		52,335 00
		129 815 00
Arrears (after reserve)		183 00*
Operating Income from the JOHNAL	\$ 5 076 05	
Plus allocation of Dues	52,335 00	57 411 05
Sundry		29 65
,		
		187 073 70
Operating Expenses		
	80 169 09	
Administrative	24 689 63	
Public Relations Bureau	59 395 68	
Medical Directory net		
Annual Meeting	1 501 23	
Logialative Bureau—Albany Office	17,220 06	
Counsel—Retainer and Expenses	16,546 58	
Traveling Exponses	11 035 61	
Planning Committee for Medical Policies	522 02	
Workmen a Compensation Bureau	17 609 21	
Bureau of Medical Care Insurance	12 886 14	
Scientific Activities	16,247 83	
Malpractice Defense and Insurance Board	1 552 12	
Committee on Cults	331 70	
District Branches	1 763 62	
Woman's Auxiliary	1 132 00	
Moving Expenses (including additional equipment)	19 316 40	
Veterans Medical Service Plan of New 1 ork	1,692 89	283 611 81
Excess Total of Operating Expenses over Income		\$ 96,638 11"

^{*} Italica denota figures in red.

\$ 455 229 70 \$ 474,154 50

TOTAL

STATEMENT OF FINANCIAL INCOME, EXPENSE AND CAPITAL For the Year Ended December 31, 1947

	TOG DOCCIMBON			
Balance at January 1, 1947	General Fund \$ 544,799 81	Lucien Howe Prize Fund \$ 4,846 19	Fund	A. W Suiter Lectureship Fund \$ 4,497 22
Additions	0 011,133 01	0 1,010 10	Ç 1,525 00	Q 1,101 DD
Interest on Bank Balances Income from Securities Profit (Net) from Sale of Securities Transferred from Reserve for Future Annual	501 06 18,348 25 9,733 64	72 97	29 04	77 60
Meetings	1,630 88			
Final Payment Received	-,			861 01
	\$ 575,013 64	\$ 4,919 16	\$ 1,958 40	\$ 5,435 83
Deductions Excess of Operating Expenses Over Income Custodian and Investment Service Fees Prizes	\$ 96,538 11 554 99			\$ 50 00
Inventory of Medical Directories (1941–42) Written Off	143 52			
Wilten On	110 02			
	97,236 62			50 00
Balance at December 31, 1947	\$ 477,777 02	\$ 4 919 16	\$ 1 958 40	\$ 5 385 83
INV	ESTMENTS			
The investments of the Societ	ts (General Fur	nd) are summari	zed as follows	
I no mer continuo de tito bodici	., (55.1014114	,	Cost	Market
U S Government Bonds (see Note A) Railroad Bonds Mortgage Preferred Stocks Common Stocks			\$ 270,765 42 11,997 25 5,291 50 22,516 49 144,659 04	\$ 278,452 37 10,230 38 5,291 50

These securities are in the possession of the Chase National Bank as Custodian for the Trustees of the Medical Society of the State of New York

NOTE A U.S. Treasury bonds in the amount of \$101 000 00 have been pledged as collateral on the bank loan.

NECROLOGY

Edmund J Barnes, M.D., Ossining, died on March 23 at the age of seventy-one A graduate of New York University and Bellevue Medical College in 1009 Dr Barnes interned at St. John's Hospital Jonkers and served as a specialist in mental diseases on the staffs of Manhattan State Hospital and Bellevue Hospital, New York City During World War I he was assistant chief allenist at Camp Dix, New Jersey In 1923 he bought Greenmount-on-Hudson Sanatorium, Ossining, and since 1937 had been its director Dr Barnes was a member of the Westchester County and New York State medical sockoties the American Medical Association, and the New York Society for Clinical Psychiatry.

Leon F Garrigues, M.D., New York City, died on April 4. In was seventy-eight years of age. He received his medical degree from New York University College of Medicine in 1891. Dr. Garrigues had served on the staffs of Mount Sinai and St. Mark's hospitals New York City, and the Jorsey City, New Jersey Medical Center For many years he was associated with the old Weet Side German Dispensary, New York City and was a member of the courtesy staff of the dispensary's successor the West Side Hospital. For a five year period he was resident physician at California Women's Hospital, San Francisco Dr. Garrigues was a member of the New York State and County medical societies and the American Modical Association.

Pasquale Giliberti, M.D., New York City died on October 29, 1946 He was seventy two years of age. Dr Giliberti was graduated from New York University College of Medicine in 1897

Philip Goldstein, M.D. of New York City died on October 27, 1946 at the age of seventy-six. He was graduated from New York University in 1892

John Goodwin Grimley, M.D., of New York City died on March 4 He was sixty-aix years of age In 1900 Dr Grimley received his medical degree from Fordham University College of Medicine One of the founders of Columbus Hospital, New York City, he later became chief surgeon there During the first World War he served as a colonel In 1930 and 1940 Dr Grimley was special deputy Hoalth Commissioner at the New York World & Fair and responsible for the health of the millions of visitors. He was a member of the New York State and County medical societies and the American Medical Association

John Thomas Hopkins Hogan, M.D., of Troy died on March 30. He was sixty-one years of age IIe was graduated from Albany Medical College in 1914. Dr. Hogan was among the first six American physicians to enter foreign soil in World War and was the first American doctor to be placed in

charge of a British hospital. He held membership in the American Medical Association, and the New York State and Remssolaer County medical societics. He was consulting physician at the Troy Hospital.

Thomas A. Kerr, M.D., of Lowiston died on March 20 at the age of eighty-four. He was gradu ated from the University of Vermont, College of Modicine, in 1885. Dr. Kerr was Lowistons first town and village health officer. He was a member of the American Medical Association and the New York State and Niagara County medical societies.

Ludwig Koempel, M.D., died on December 31 1947, at the age of eighty two His home was in Brooklyn Dr. Koempel was graduated from the Long Island College Hospital in 1899 He was attending surgeon at Bothany Deaconess Hospital Prooklyn. He was a member of the Kings County and New York State medical societies and the American Medical Association.

Lawrence Levy, M.D., the Bronx, died on September 14 1946 He was fifty years of age Dr Levy was graduated from Cornell University College of Modicine in 1923.

Frederick W Rice, M.D., died at his home in New York City on March 30 He was sixty-eight years of age. A practicing obstetrician in New York City for almost forty years Dr Rice was a member of the department of obstetries at New York University College of Medicine for twenty-one years He resigned his professorship and his post as attending obstetrician at Bellevue Hospital in 1934 but continued as consultant at Bellevue. From 1930 to 1931 he was a member of the administrative board of Doctor's Hospital, New York City and chairman of the hospital's committee on obstetrics.

Dr Rice was also consultant to the Holy Angels Hospital Teaneck, Now Jersey, Margaret Hague Memorial Hospital, Jersey City New Jersey and Norwalk General Hospital, South Norwalk, Connecticut. He was a fellow of the American College of Surgeons and a member of the Academy of Medicine and the Now York Obstetrical Society Dr Rice received his medical degree from Columbia University College of Physicians and Surgeons in 1906

Anthony Edward Sojewicz, M.D., Syracuse, died on February 17 He was thirty-nine years of age He was graduated from the College of Medicine, Syracuse University in 1934 and served his internship at St. Many's Hospital, Detroit, Michigan. In 1936 he opened his office in Syracuse. Dr Sojewicz served in the Army Medical Corps in World War II. He was a member of the Onondiga County and New York State medical societies and the American Medical Association.

MEDICAL NEWS

Lasker Award for Outstanding Service in Mental Hygiene

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The Lasker Award was established in 1944 by the Albert and Mary Lasker Foundation and was presented in that year to Colonel William C. Menninger, M.C., chief consultant in neuropsychiatry, Office of the Surgeon General, U.S. Army, for his outstanding contribution to the mental health of men and women of the armed forces

Subsequent awards have been made to Dr John

Rawlings Rees, consultant in psychiatry to the Directorate of Psychiatry of the British Army, and Major General G Brock Chisholm, deputy minister of national health, Federal Department of National Health and Welfare, Canada, for outstanding service in rehabilitation, to Dr D R. Sharpe, of the Cleveland Baptist Association, and Mr Walter Lerch, of the Cleveland Press, for outstanding contribution to the improvement of mental hospitals, to Dr W Horsley Gantt, of Johns Hopkins University, for significant investigation into behavior deviation, and to Miss Catherine Mackenzie, of the New York Times, and Mr Lawrence K Frank, of the Caroline Zachary Institute of Human Development, New York City, for most significant contributions to popular adult education, especially in parent-child relationships

Anyone may submit nominations, which should be forwarded by September 1 to the National Commuttee for Mental Hygiene, at 1790 Broadway, New York City 19 Further information will be supplied

on request

Institute for Research in Psychotherapy

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The program for the Institute will include

Training, (2) Therapy, (3) Research, (4) Education Further information on this program may be ob-tained from Dr. Emil A. Gutheil, Director of Education, Institute for Research in Psychotherapy, Inc., 218 East 70th Street, New York City 21

Grants Made for Alcoholism Research

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A grant of \$30,000 went to Cornell University Medical College, as the second installment of a fiveyear project at the New York Hospital-Cornell Medical Center, which is under the direction of Dr Oskar Diethelm, professor of psychiatry at Cornell

and psychiatrist-in-chief of the New York Hospital. New York University, College of Medicine, re-ceived \$20,000 for a study on biochemical and endocrinologic factors in alcoholism This study is to be undertaken in the department of medicine, under the direction of Dr James J Snuth

American College of Surgeons Approves Use of Nurse Anesthetists

THE BOARD of Regents of the American College THE BUARD of Regence of the same adopted a resolution commending the services of nurses who have had special training in the administration of anesthesia and recommending the continuance of training courses in this field for nurses

The resolution reads as follows "The American College of Surgeons regards with deep concern the actions of some physician anesthesiologists in giving the impression to the laits in the public press that it is unsafe for experienced nurse anesthetists to conduct surgical anesthesia. While it supports the increasing tendency of having physician anesthesiologists in charge of surgical anesthesia, it deplores at this time any propaganda for the elimination of the trained nurse anesthetist. On the contrary, the American College of Surgeons is of the opinion that, in view of inadequacy in the number of the physician anesthesiologists and in view of the splendid record of achievement of the nurse anesthetists, institutions engaged in the training of nurses for this should be encouraged to continue their programs

National Society Opens First Clinic to Study Multiple Sclerosis

THE FIRST research clinic in a projected series of clinics to investigate the incapacitating nerve disease multiple sclerosis, was opened in March at the Beth Israel and Boston State hospitals in Boston, Massachusotts, through a grant from the National Multiple Sclerosis Boschety, with headquarters in the New York, Academy of Medicine Building New York, Caty

Another clinic will be opened soon in the Albany Hospital, Albany Neurologists of the Albany Medical College will cooperate with the Division of Research and Laboratories of the New York State Department of Health in conducting the research it was announced. As soon as funds permit the Society will catablish other multiple sciences rearch clinics in leading cittles across the country.

Psychiatric Residencies Available in Kings County

THE PSICHIATRIC Division of the Kings County Hospital, Brooklyn has been approved for psychiatric residency training and has a number of residents positions available for appointment, according to an announcement by Dr Sam Parker director of psychiatry

This is a new and completely self-contained psychiatric hospital, comprising laboratories, all medical and surgical facilities complete psychiatric and therapeutic service, as well as a full time Mental Hygeno Clinic, handling every form of adult and child psychiatric problem in the community. These services include separate childrens and adolescents

psychiatric wards, prisoners, alcoholics geriatics

psychonourotics and psychotics, as well as psychosomatic consultation on medical services of the general hospital. There are also a psychiatric library and an intimate consultation relationship with pediatric neurosurgical and neurologic services of the general hospital.

This hospital is now affiliated with the Long Island College of Medicine and opportunities are available for degrees in graduate work during the residency. The standard residents' salary of New York City Department of Hospitals is \$1 500, with maintenance. Appointments with "living out" can be arranged, but no salary increase in heu of main tenance in provided.

More Children Should Be Protected Against Diphtheria

SEVENTEEN upstate municipalities are on the bonor roll. They have immunised at least 70 per cent of their preschool population against diph theria. According to the records of the State Department of Health these municipalities are

Binghamton Hudson Irondequott, Little Falls, Mamaroneck, Middletown Newburgh Nigaran Falls, Ordensburg Osaning Oswego Peckskill, Purt Chester Rochester Syracuse Watertown and White Plains. Figures are based on populations estimated by births and deaths as of December 31 1947. The actual number of immunications reported as having been done in 1947 was 36 per cent less than in 1946.

The number of cases of diphtheria is yet consider ably above the number reported in the period 1940 through 1944 when an average of only 65 cases occurred yearly. In 1946 there were 339 cases and 30 deaths, and in 1947 200 cases and 12 deaths. On far this year a total of 34 cases has been reported.

MEETINGS

PAST

New York Council of Surgeons

Dr Arthur Ettinger, associate reentigenologist at Morrisania City Hospital, spoke on Interesting \ Ray Cases at the meeting of the New York Council of Surgeons April 6 at the larkehexter General Hospital the Bronx.

New York Chapter Association of Military Surgeons of the United States

To consider the problems of medical constraints for New York City a joint meeting of the New York Chapter of the Association of Mintary Surscens of the United States and the New York Leademy of Medicine was held on April 6 at the Academy

The program included the following addresses Lessons Learned in World War II Relating to Medical Lengence, Preparedness, Dr. Georgo Bachr, president, New York Academy of Medicine, The Problems of Disaster Control in the Event of Atomic Warfare, Capitain (corge M Lyon, MC, USNR chief of Radio Isotops Section Contral Victorias Administration) (urrent Studies of

Bederal Medicine," Rear Admiral Joel T Boone, MC USN executive secretary. Committee on Medical and Hospital Services of the Armed Forces, and Medical Cooperation in Civilian Defence, 'Brigadier General George E. Armstrong, Deputy Surgeon General U.S. Army

Society of Medical Jurisprudence

Problems of aging were discussed at the 633rd regular meeting of the Society of Medical Jurispru dence held April 12 at the New York Academy of Medicine. Speakers and their topics included: Dr Frederic D Zeman ellinical lecturer in medicine, Columbia University, College of Physicians and Burgeons, and consultant Adjunct Geriatric Series, Willard Parker Hospital, 'Social and Medical Problems of Our Aging Population Dr Sigmund Epstein, Tantern Slide Presentation Showing Scalle Bowing of the Spine and Origin of the Term Geriatrics from Ancient Greek Art Reproduction, and Richmond J Resse Legal Spects of the Subject, with Special Reference to Age in Relation to Testamentary Capacity

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of Districts Nine and Ten at the Troy Club on February 17 Dr William Goldring, New York University School of Medicine, on '1 resent Status of the Medical and Surgical Treatment of Hypertension as first lecture in annual Samuel Strausberg Memoral Locture Series sponsored by medical staff of Beth-El Hospital, Brooklyn on February 17 Dr Harold W Kipp, Oesining, on 'Recent Advances in Surgery' at a meeting of the Ossining Rotary Club on April 7

Dr Ell Loven, chairman of heart committee of Monroe County Medical Society on Rheumatic Fever" at a meeting of the Brighton Child Sudy Group on March 2 in Brighton Dr Milton I Levine, assistant professor of pediatrics, Cornell University Medical College, on The Sex Problems of the Growing Child' at the second of the Child Study Lecture and Discussion Series, sponsored by the School Community Association, March 8 in Manhasset Dr Andre Levoff of the Pasteur Institute, Paris France on April 7, delivered the 45th annual Christian A. Herter Lecture at New York University College of Medicine on 'Aspects of Biochemical Evolution.'

Dr M. Edward Marten Brooklyn as chairman

of the session on "Medice-Legal Aspects of Noplasia at the meeting of the American Association for the Study of Neoplastic Diseases, April 15–16 and 17, at Garfield Memorial Hospital, Washing ton DC Dr Ramsey Spillman, New York City as chairman of the session on "Radiation" at the same meeting Dr John Remington Jr consultant at Rochester State Hospital on cancer, at a meeting of the Practical Nurses of New York, Western Division on March 2 in Rochester

New Offices

Dr Gunter J Bach, Long Island City, general practice in Croghan Dr Hamilton Boyd, recently discharged from medical department of U.S Army Air Force, practice of obstetrice in Kingston Dr Louis Eisenberg, Long Island City genoral practice in Canisteo Dr Frank R. Hall and Dr Loren B Manchester, joint offices for general practice in Batavia Dr Sidney C Werner consultant at Grasslands Hospital, Valhalla, and a member of teaching staff at Columbia Preclyterian Hospital, New York City general practice in Scarsdalo Dr Ronald P Smith formerly of Watertown practice of ophthalmology in Plattaburg.

COUNTY NEWS

Albany County

Dr. Ralph Colp clinical professor of surgers, Columbia University College of Physicians and Surgeons, spoke on Various Aspects of Gallbladder Ducase, at the meeting of the Albany County Medical Society on March 24 at the Albany College of Pharmacy Drs. Edward Sharkey and Harry Jasper discussed the paper

Drs. Lewis W Barton, Crawford J Campbell, and Dominick A. Papandrea have been elected to memberahip in the Albany County Medical Society

Dr. Morns Fishbein, Chicago editor of the Sourcal of the American Medical Association, was guest speaker at the third annual dinner for physicians of Albany and Renseclaer given by the Albany Pharmaceutical Association on April 20 in Albany

Bronx County

The Lie Detector and Its Functions was the topic of the March meeting of the Bronx County Medical Society, held March 17 at the Concourse Plats Hotel. Speakers were Joseph F Kubis, Ph.D., associate professor of psychology, Fordham University Graduate School and Mir Louis Susman, former president of the Bronx County Bar Association.

The meeting program was arranged by the Public Relations Commuttee of the County Society

Broome County

Endorsement of Broome County's new blood bank project was voted at the February meeting of the Broome County Medical Society, and announced in a letter from Dr. Haymond S. Mckooby secretary to Mr. George F. Mulqueen, chairman of the Public Health Committee of the County Board of Super visors. The sum of \$25 000 has been appropriated by the Board of Supervisors for establishing and operating a county blood bank this year with rumbursement up to \$10,000 assured by the State to help finance the first year's operation

Gattaraugus County

Dr Herbert H. Bauckus, Buffalo, and Dr William Smith, Olean spoke on "Socialized Medicine," and Mr Thomas E. Walsh field representative of the State Society's Public Relations Office, spoke on Legislation" at the meeting of the Cattaraugus County Medical Society and Woman's Auxiliary, held February 12 in Olean

An eight page pamphlet, Your Health Department, has been prepared and distributed by the Cattaraugus County Health Department, including pictures and explanatory text on the application and importance of many of the department's activities.

Clinton County

Dr Ivan Hekimian assistant professor of medicine and associate in therapeutics, University of Buffalo School of Medleme, spoke on 'The Modern Management of Thyrold Dystrophy' at the meeting of the Clinton County Medical Scorety on April 15 at the Champlain Valley Hospital, Plattsburg This postgraduate instruction was arranged for

This posteraduate instruction was arranged for the County Society by the Council Committee on Public Health and Education of the State Society in cooperation with the State Department of Health

Delaware County

A hospital survey committee of the Delaware County, Modical Society has advocated construction of six 50-bed hospitals at points throughout the county it was reported at a meeting of the County Society in Delhi.

In advocating several hospitals at strategic points, the committee pointed out that the county is large geographically, and that there are many communities which would be a considerable distance from any centrally located hospital

Dutchess County

At the March meeting of the Dutchess County Medical Society, held March 10 at the Hudson River State Hospital, Poughkeepsie, Dr. Robert H. Kennedy, director of surgery at the Beekman Downtown Hospital, New York City, was the guest speaker His subject was "Modern Treatment of Fractures."

The annual meeting of the Dutchess County Branch of the American Cancer Society was held on March 27 in Poughkeepsie Following a luncheon and business meeting, Dr Paul Gerhardt, director of the Division of Cancer Control of the State Department of Health, spoke on cancer

Erie County

Since, by proclamation of President Harry Truman, the month of April was designated as National Cancer Control Month, the Eric County Medical Society, cooperating in the national observance, designated its April 27 meeting as "Cancer Control Night" Arrangement and presentation of the Night" Arrangement and presentation of the program was in charge of the Society's Committee on Cancer Control, of which Dr Samuel Sanes is chairman

Sponsored by the Eric County Medical Society and its Special Committee on the Problems of Alcohol, a meeting of medical men, law enforcement officials, religious and social welfare leaders, industrial heads, and representatives of press, radio, and other organizations and interests was held on March 18 in Buffalo, to launch the Western New York Committee for Education on Alcoholism, Inc
The committee will serve the six counties of Erie

Niagara, Genesee, Wyoming, Chautauqua, and Cattaraugus, constituting the newly established Buffalo Health Region of the State Health Depart-

ment

Dr E Dean Babbage, president of the Eric County Medical Society, presided at the organization meeting Directors of record and incorporators include Dr Milton G Potter, chairman of the Society's Special Committee, Dr Berwyn F Mattison, Eric County Health Commissioner, John N Garver, Elmer J Tropman, executive secretary, Council of Social Agencies, R D Stevens, and Sunderland P Gardner, chairman of the Committee Sunderland P Gardner, chairman of the Committee on Alcoholism of the Council of Social Agencies of Buffalo and Eric County

Purposes of the Western New York Committee for Education on Alcoholism, Inc , as set forth in the "To study the certificate of incorporation, are problems of alcoholism and to collect data, statistics, and information in reference thereto, to make this knowledge and information effectual in solving the problems of alcoholism as they affect the individual and the community, to increase public understanding of the problems of alcoholism, its nature and treatment, by means of newspapers, radio, public speeches, and any and all other means of communicating knowledge which may be available, the establishment of a clinic for the study of alcoholism

and the diagnosis and treatment of alcoholics, to promote better hospital facilities for care and treatment of alcoholics, to establish an information center for the disbursement of available information relating to alcoholism and its treatment, to buy, sell mortgage, lease, or exchange real and personal property

Franklin County

Dr Alfred A. Hartmann, Malone, was elected president of the Franklin County Medical Society at its meeting on March 4

Other officers elected are Dr Carter Morse, Tupper Lake, vice-president, Dr Daisy H Van Dyke, Malone, secretary-treasurer, and Dr Van Dyke, delegate to the State convention

Fulton County

Two programs of postgraduate instruction, arranged by the Council Committee on Public Health and Education of the State Society, have been held for members of the Fulton County Medical Society during March and April

On March 25, Dr Edward C Hughes, professor of obstetrics, Syracuse University College of Medicine, spoke on "Tovemias of Pregnancy," at the

meeting in Johnstown

Dr Eldridge Campbell, professor of surgery, Albany Medical College, spoke on "Spontaneous Subarachnoid Hemorrhage and Aneurysm of the Circle of Willis" at the April 22 meeting, held in Gloversville

The instruction was provided with the cooperation of the State Department of Health

Herkimer County

Dr Nicholas Lill, Dolgeville, presented a paper on penicillin and streptomy cin at the February meeting of the Herkimer County Medical Society, held in Herkimer Dr Robert W Dennis, president of

the group, was in charge of the meeting
Dr W A Jarrett, Herkimer, and Dr Eugene
Retzbach, Old Forge, were admitted as new mem-

bers

Jefferson County

Dr A Wilbur Duryee, attending physician and chief of the Peripheral Vascular Clinic, New York Post-Graduate Hospital, spoke on "The Management of the Thrombotic Problems Associated with Peripheral Vascular Disease" at the meeting of the Jefferson County Medical Society, April 8 in Watertown

On May 13, at the Hotel Woodruff, Watertown, Dr Richard S Farr, professor of orthopedic surgery, Syracuse University College of Medicine, will speak on "Treatment of Low Back Pain" at a meet-

ing of the group

Both lectures were postgraduate instruction, arranged by the Council Committee on Public Health and Education of the State Society with the cooperation of the State Department of Health

Kings County

Dr Laurence H Snyder, dean of the Graduate College at the University of Oklahoma, spoke on "Medical Genetics as an Aid to the Practice of Medicine" at the meeting of the Kings County Medical Society on April 20

At the March 16 meeting, Dr Walton Van Winkle, from the American Medical Association headquarters, Chicago, spoke on "Current American Medical

Association Activities

Lewis County

The Lewis County Medical Society has given its approval to the plan for mothers classes to be sponsored by the Lyons Falls Women a Club The series of six lectures and discussion periods are to be under the direction of a member of the Lewis County Public Health Nursing Service.

Subjects include anatomy and by giene of preg nancy nutrition, clothes and equipment for mother and baby, preparation for delivery feeding the

haby and auxth-week examination.

Livingston County

The Livingston County Medical Society and its Woman's Auxiliary were addressed by Dr Herman Pearse at a joint meeting on March 24 His subject was Experiences in Japan and Observations on Late Effects of the Atomic Bomb

Madison County

During April three sessions of postgraduate in struction were arranged for the Madison County Medical Society by the Council Committee on Publie Health and Education of the State Society and were held on consecutive Thursday nights in Oncida.

Lecturers and their topics included April 8-Gynecology in General Practice Dr Chester E. Carl professor of gynecology Syracuse University College of Medicine April 15— Operative Deliveries the Occupatoposterior Position Deliveries College of Medicine April 25— Operative Deliveries College of Medicine, and April 22— Problems in Inysical Diagnosis, 'Dr William University College of Medicine, and April 24— Problems in Inysical Diagnosis,' Dr William University College Of Medicine, and April 24— Problems in Inysical Diagnosis,' Dr William University College Of Medicine, and April 24— Problems in Inysical Diagnosis,' Dr William College Of Medicine, and Coll McNerney professor emeritus of clinical medicine, byracuse University College of Medicine.

Health needs of Madison County as observed in a survey made last year were outlined and discussed at a meeting of the Hamilton Community Forum in Hamilton on February 15 with Dr John J Bourke director of the New York State Joint Hospital Sur

vey and Planning Commission as principal speaker
In addition to Dr Bourke Dr Evelyn Rogers
Utica district health officer Dr William Liddle Onesda, chairman of the County Board of Super visors public health committee and Dr Richard Cuthburt, Canastota president of the Madison County Medical Society spoke

Nassau County

Dr A. W Martin Marino, assistant professor of funical surgery. Long Island College of Medicane, spoke on Larly Diagnosis of Cancer of the Rectum, at a joint meeting of the Nassau County Medical Society and the Nassau County Cancer Committee in Garden City on April 27

On Tuesday night, Mny 25 at 9 00 PM Dr Robert M Marcusson research fellow in medicine Cornell University Medical College will speak on Treatment of Migraine at a meeting to be held at

the Cathodral House Garden City

At the meeting on March 30 a talk on 'The Use of Anticongulants in the Treatment of Diseases of the Heart and Blood Vessels' was given by Dr William T Foley, instructor in internal medicine Cornell University Medical College

All three lectures were postgraduate instruction arranged by the Council Committee on Public Health and Education of the State Society with the experation of the State Department of Realth

New York County

"The Present Status of Cancer Control ' was the topic of the scientific program presented at the topic of the serienting program presented to the new York County Medical Scelety on March 22 at the New York Academy of Medicate with Dr Cornelius P Rhoads presiding Papers presented included __Too Detection of

Pulmonary Neoplasms by the Cytology of Sputum,'
Dr John R. McDonald, Mayo Clinic Rochester
Minnesota, "Early and Differential Lesions of the Breast, Dr Herbert Willy Meyer 'The Treat ment and Progness of Skin Cancer' Dr John Gerster, "The Neoplastic Lesions of the Large Gerster, "The Neoplastic Lesions of the Large Bowel," Dr Michael Deddish 'Mass Roentgeno-graphic Studies of the Stomach' Dr Harold D Harvey 'The Neoplastic and Prenceplastic Le-sions of the Oral Cavity' Dr Adolph Berger and Larly Cervix Cancer' Dr Howard C Taylor, Jr

A panel discussion on thoracic surgery was held at the February meeting with Dr Herbert C Maier at the reorder meeting with Dr Heroert C Maler as moderator Participating as members of the panel were Dr J Burns Anburson Dr Arthur S W Touroff, Dr Laurence Miscall, and Dr Carl Muschenheim

Niagara County

Dr Ramedell Gurney of the University of Buffalo Medical School and the Buffalo General Hospital spoke on "Dypsnea' at the meeting of the Viagara County Medical Society on March 9 in Lockport.

At the February meeting held in Niagara Falls, a panel discussion on the duties and responsibilities of nurses and doctors in the operation of plant compensation medical bureaus and first aid stations was beld

Members of the panel who took part in the compensation forum included Alexander Bradt, ditrict administrator of the Workmen & Compensation Board of the State Labor Department, Miss Iona B Riedel Mrs. Dorothy L. Anker, and Mrs Roma D Riccici Vira Dorotta) in Amer, and airs around pressent president, executive secretary, and chair man, respectively, of the Industrial Committee of the State Vursea Association, and Joseph J Guarquilla, secretary of the Workmen's Compensation Committee of the Erre County Medical Society.

Dr Guy S Philbrick, chairman of the Niagara County Medical Society's Workmen's Compensa

tion Committee acted as moderator

Oneida County

A symposium on rheumatic fever was the program of postgraduate instruction at the last meeting of the Oneida County Medical Society hold April 13 Arranged by the Council Committee in Ution. on Public Health and Education of the State Society with the cooperation of the State Department of Health the symposium included The Diagnors of Rheumatic Fever, Dr T Duckett Jones, medical director of the Helen Hay Whitney Foundation New York City Hospital and Convalescent Care of the Rheumatic Fever Patient, Dr Leo M Taran, director of St. Francis Sanatorium, Roslyn, Long Island and Community Programs Dr J C Fred Illes professor of clinical medicine, Syracuse University College of Medicine.

A committee on rheumatic fever and rheumatic heart disease has been appointed by the Onerda County Medical Society Headed by Dr W H. Willia, the committee is now engaged in developing a comprehensive program to deal with problems concerning rhoumatic fever in the county

Serving with Dr Willis on the committee are Drs M J A'Hearn, Harry Davis, A Graham Davis, S A Mahady, David E Bigwood, Rocco Martoccio, W H Williams, J W Dimon, T Douglas Kendrick, Edward R. Evans, Joseph J Witt, D R. Rosendale, Rudolph E Vandeveer, Edwin R. Russel, Evelyn Rogers, Philip Gold, T Wood Clarke, and Arthur Kaplan

Dr James I Farrell, Utica, was elected president of the Oneida County Medical Society at the annual meeting in January Other officers are Dr W C Schintzius, Boonville, vice-president, Dr Harold H Dodds, secretary, Dr Verne Johnston, assistant secretary, Dr R. D Hall, treasurer, and Dr E G Evans, librarian

Onondaga County

A paper on "Tumors of the Colon and Rectum" was presented by Dr G Gowing Broad at the meeting of the Onondaga County Medical Society April 6 in Syracuse Dr John Van Duyn showed a plastic surgery motion picture

A clinical pathologic conference, with Dr L G Berman as moderator, featured the scientific session of the March meeting of the County Society, held

on March 2 in Syracuse

For the February meeting, the program was under the auspices of the staff of the Crouse-Irving Hospital, Syracuse, who presented a discussion on "Lumps in the Breast"

Unanimous-endorsement of the proposal to establish a State medical center in Syracuse was voted by the Onondaga County Medical Society at a meeting February 3 Copies of the resolution, which set forth reasons why the Society believes the State should select Syracuse for the site, were forwarded to Governor Dewey and other officials

The resolution pointed out that the Syracuse University College of Medicine would provide "an admirable nucleus for a great medical center" with its "surrounding clinical facilities"

Ontario County

"Recent Advances in Diseases of the Liver" was the topic of the lecture presented by Dr Jacob D Goldstein, assistant professor of medicine and bacteriology, University of Rochester School of Medicine and Dentistry, at the meeting of the Ontario County Medical Society April 13 in Canandaigua

The postgraduate instruction was arranged by the Council Committee on Public Health and Education of the State Society, with the cooperation of the State Department of Health

Orange County

Sponsored by the Orange County Medical Society, a series of tumor detection clinics in communities throughout the county is being arranged. For the purpose of detection only, the clinics will not treat any cases, but will advise patients with detected tumors to consult their own physicians

At a recent meeting of the Newburgh Public Health and Tuberculosis Association, Dr A Stuart Ferguson, chief attending physician at the Heart clinic of St Luke's Hospital, Newburgh, presented a program to combat rheumatic fever The program has the approval of the Orange County

Medical Society, and recommends the formation of a local heart association to correlate the work of

the lay organizations

Dr Ferguson advised the institution of an adequate follow-up program of physical defects found in school children, stressed an educational program on heart disease, especially for rheumatic heart ailments, and recommended preschool heart examinations for all children, with the establishment of a central registry for the reporting of all suspicious or proved rheumatic or other early heart ailments

Oswego County

Programs of postgraduate instruction, arranged y the Council Committee on Public Health and Education of the State Society, with the cooperation of the State Department of Health, were presented during March and April at meetings of the Oswego County Medical Society

Dr J G Fred Hiss, professor of clinical medicine, Syracuse University College of Medicine, spoke on "What Can Be Done about Rheumatic Fever as a Public Health Problem" at the March 30

meeting in Fulton

On April 27, at the meeting in Oswego, Dr Jesse Tolmach, compensation medical examiner, New York State Workmen's Compensation Board, spoke on "The Evaluation of Disability",

Queens County

Two programs, arranged by the Committee on Graduate Education, were given during April for members of the Queens County Medical Society On April 2, Dr John Emmett, instructor, Depart-ment of Public Health and Preventive Medicine, Cornell University Medical College, spoke on "Common Parasitic Infections Encountered in General Practice," and on April 16, Dr Leslie P Barker, assistant professor of dermatology, Columbia Unversity, College of Physicians and Surgeons, spoke on "Recent Trends in Penicillin Treatment of Syphilis"

During March, a series of four Wednesday afternoon lectures were given by Dr Jerome H Schwartz, supervising psychiatrist at Creedmoor State Hos-

pital and assistant neuropsychiatrist at Queens General Hospital, on the subject of "Psychiatry" Dr Marcus D Kogel, general medical superintendent, Department of Hospitals, City of New York, "Department of Hospitals, City of New York, "Property of Atomy Frances," "Medical Appears of Atomy Frances," and property of Atomy Frances, and A York, spoke on "Medical Aspects of Atomic Explosion" at the stated meeting of the Queens County Medical Society on March 30 Also on this program
Dr Theodor Rosebury, associate professor of
bacteriology, Columbia University, spoke on bacteriology, Colum "Biological Warfare"

At the February meeting, Dr Alexander Brunschwig, professor of clinical surgery, Cornell University Medical School, spoke on "The Surgical Treatment of Advanced Abdominal Cancer"

Richmond County

The annual dinner of the Richmond County Medical Society was held on April 7 at the Meurot Club, St George, Staten Island Dr John J

Goller was chairman for the event

A symposium on cancer of the stomach was presented for the Richmond County Medical Society on March 26 at the United States Marine Hospital, Stapleton Participants and their subjects included Drs John S LaDue and Paul J Murison, "The Symptomatology of Gastric Cancer", Dr Juan M Jimenez, "The X-Ray Diagnosis of Cancer

of the Stomach , Dr William Trevor "Sarcoma of the Stomach', Dr Isabel M Scharnagel, "The Gastroscopic Diagnosis of Gastric Cancer", Dr Robert J Booher "Tumors of the Ampulla of Vater and Dr Georgo T Pack, 'Methods of Surgical Treatment and End Results

At the March 10 meeting, Dr Joseph Diamond presented a scientific paper on "Homologous Serum Hepatitis, and Dr D V Catalano gave a paper on "Endometricsis."

Rockland County

Arranged by the Council Committee on Public Health and Education of the State Society, with the cooperation of the State Department of Health two programs of postgraduate instruction are being presented for the Rockland County Medical Society

On April 14 Dr James P Palmer associate cancer gynecologist Roswell Park Momorial Institute Buffalo, spoke on The Recognition and Treatment of Pelvic Cancer at the mooting held at the Summit Park Sanatorium Pomona.

On Wednesday, May 5 Dr John C M Brust, associate professor of surgery Syracuse University College of Medicine, will speak on Cancer of the Rectum and Colon-Present-day Concepts meeting will begin at 4 30 r M and will be held in the Recreation Pavillon, Summit Park Sanatorium Pomona.

St Lawrence County

During the past three months three programs of postgraduate instruction have been presented at meetings of the St. Lawrence County Medical So-ciety arranged by the Council Committee on Public

Health and Education of the State Society On February 12, in Ogdonsburg Dr Gray H Twombly assistant professor of cancer research, Columbia University, College of Physicians and Surgeona, spoke on Recognition and Treatment of Petro Const. Pelvic Cancer' On March 11 in Potsdam, Dr Wardner D Ayer professor of clinical medicine Syracuse University College of Medicane spoke on Neurology in General Practice and on April 18, in Massena, Dr. A. Wilbur Duryee chief of the Peripheral Vascular Clinic, New York Poet-Graduate Hospital, spoke on "The Managument of the Thrombotic Problems Associated with Ponpheral Vascular Depoke on "The Managument of the Thrombotic Problems Associated with Ponpheral Vascular Depoke on "The Managument of the Thrombotic Problems Associated with Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated with Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated with Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated with Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated with Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated with Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated with Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated with Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Managument of the Thrombotic Problems Associated With Ponpheral Vascular Depoke on The Vascular Disease.

Saratoga County

Dr James E McCormack, assistant dean and Instructor in modicine New York University College of Mcdicine spoke on Chemotherapy and the Antibiotics at a meeting of the Saratoga County

Medical Society held April 22 at Saratoga Springs. The lecture was postgraduate instruction arranged for the County Society by the Council Committee on Public Health and Education of the State Society with the cooperation of the State Department of Health

On March 10 a rhoumatic fever clinic was opened in the Saratoga County building in Saratoga Springs. one of the first such clinics to be opened in New York State.

Made possible through the cooperation of the Board of Supervisors the Saratoga County Labora tory, the public health nurses and the Saratoga County Tuberculosis and Public Health Association the clinic is being conducted by the Saratoga

County Medical Society, with Dr. H. Dunham Hunt chairman of the committee.

According to Dr Hunt, Rheumatic fever is the greatest single killer of children between the ages of 10 and 14 and we live in a zone of the greatest incidence of this disease in the country

Schenectedy County

A resolution recommending the continuance of Schenectady County's venereal disease clinic on a curtailed basis was adopted at a meeting of the Schenectady County Medical Society in February and forwarded to the Board of Supervisors State health authorities had urged the abandonment of the clinic on the grounds that the venercal disease rate was low and did not justify the expense, of which the State contributes half

At the March meeting of the Schenectady County Medical Society, Dr Thomas H. Lanman, assistant professor of surgery Children & Hospital Boston Massachusetts, spoke on 'Abdominal Surgery in Infants and Children'

Suffolk County

Dr Henry H. Ritter professor of clinical surgery. New York Post-Graduate Medical School spoke on 'The Treatment of Common Fractures' at the meeting of the Suffolk County Medical Society held April 28 in South Huntington.

The postgraduate instruction was arranged by the Council Committee on Public Health and Education

of the State Society with the cooperation of the State Department of Health.

Sullivan County

Postgraduate instruction in 'Gynecology been arranged by the Council Committee on Public Health and Education of the State Society for the Sullivan County Medical Society with a series of six Wednesday night lectures during April and May Speakers and their topics include

April 7-Dr William Filler instructor in obstetrics and gynecology, New York University College of Medicine "Dysmenorrhoa and Func

tional Bleeding Liberty
April 14—Dr Gray H. Twombly assistant profeesor of cancer research, Columbia University College of Physicians and Surgeons Recognition and Treatment of Pelvic Cancer' Monticello

April 21—Dr George P Heckel, assistant pro-fesser of obstetries and gynecology University of Rochester School of Medicine and Dentistry Practical Application of Endocranes in Gynecol-Liberty

April 28—Dr Clyde L. Randall professor of gynocology University of Buffalo School of Medi-cine "The Office Management of Femalo Pelvic

Disordors, Liberty
May 5-Dr Ferdinand J Schoenock, professor of

clinical obstotries Syracuse University College of Medicine Storilty, Monticello May 12—Dr Chester D. Clark, professor of gynecology Syracuse University College of Medi-

cine 'Gynecology in General Practice Liberty

Tloga County

At the meeting of the Tioga County Medical Society on April 28 in Waverly postgraduate in-struction was presented by Dr Paul A. Bunn

associate professor of medicine, Syracuse University College of Medicine, who spoke on "Recent Advances in Antibiotics," and Dr Richard H Lyons, professor of medicine, Syracuse University College of Medicine, whose topic was "Recent Advances in Other Forms of Therapy"

Dr Irving Ershler, associate attending physician, Binghamton City Hospital, Binghamton, was the speaker at the March 9 meeting of the Tioga County Medical Society, in Waverly His topic was "The Medical Society, in Waverly His topic Treatment of Congestive Heart Failure"

Tompkins County

Dr Ferdmand J Schoeneck, professor of clinical obstetrics, Syracuse University College of Medicine, spoke on "Gynecology in General Practice" at the meeting of the Tompkins County Medical Society, held March 15 in Ithaca

The lecture was arranged by the Council Committee on Public Health and Education of the State Society, with the cooperation of the State

Department of Health

Ulster County

"New Concepts in Protein Metabolism of Clinical Significance" was the topic of Dr L Corsan Reid, associate professor of physiology, New York University College of Medicine, when he gave a lecture as postgraduate instruction for the February meeting of the Ulster County Medical Society, in Kingston

On April 6, in Kingston, Dr John Frosch, assistant clinical professor of psychiatry, New York University College of Medicine, spoke on "Psychotherapy in General Practice"

Both lectures were arranged by the Council Committee on Public Health and Education of the State Society, with the cooperation of the State Department of Health

Wayne County

Dr Milton Halpern, deputy chief medical exammer of New York City, spoke on "Criminologic Medicine and the Functions of the Medical Exammer's Office" at a joint meeting in February, held in Lyons, of the Wayne County Medical Society the Wayne County Bar Association, and the Wayne County Dental Society

Westchester County

Dr Herman E Hilleboe, New York State Health Commissioner, spoke on "Plans for Improving Public Health in New York State" at the meeting of the Westchester County Medical Society, held March 16 in White Plans

At the April 20 meeting, Dr Charles G Child, associate professor of chinical surgery, Cornell University Medical College, spoke on Recent Advances in

Pancreatic Surgery

CORRESPONDENCE

The Nursing Situation

To the Editor

Your editorial, "More Nurses Needed," which appeared in the January 15 issue, contains the statement, "It would seem that the best approach to the problem of getting more nurses would be an intensive campaign by the nursing profession itself "

And for your information, we That is very true would like to point out that the American Nurses' Association, which represents more than 160,000 registered nurses, is sponsoring just such a program

Since last September, the American Nurses' Association has been conducting a vigorous campaign to bring home to the public the facts about the nursing shortage, its effects upon our health standards, and, most important, its causes

has already borne fruit

In those six months, we have received countless letters of support from leading individuals and organizations throughout the country The press has devoted a very fair share of news space to an explanation of the nursing situation Hundreds of editorials have been written in support of the program of the American Nurses' Association Radio stations from coast to coast have broadcast announcements carrying the story of the crisis to the American public

In the last analysis, of course, it is the American

public who must resolve this crisis

It is obvious that a vast nurse recruiting cam-

paign alone will not be able to attract a sufficient number of qualified young women We see on the one hand an unprecedented demand for nurses, insuring jobs for as many qualified women as may care to enter the profession. Yet on the other hand, seemingly in defiance of long established economic concepts, women remain away from the nursing field Why? What are the causes of this paradox?

We visualize these causes as being the lack of job security and the low financial status of our nurses, madequate legal control of nursing, and an madequate distribution of available nursing service. When the situation in the nursing profession has improved, we should then see an influx of candidates. for nursing schools, and we will have gone a long way towards overcoming the nursing shortage

The American Nurses' Association, representing more than 160,000 registered professional nurses, is proud of the fact that it has undertaken, in your own

words, "a vigorous campaign" to do just that

ELLA BEST, R.N Executive Secretary, American Nurses' Association

ich Fork City February 24, 1948

We are pleased to acknowledge this co-Note operation Editor

HOSPITAL NEWS

Presbyterian Hospital Marks Twentieth Anniversary

PRESBYTERIAN Hospital in New York City, has provided 8 900,000 patient-days' care of which I,500 000 were free days for ward patients during its twenty years of occupancy of the Columbia Presbyterian Medical Center 11 was announced in connection with the anniversary in March. In the period, almost 50 000 babies were born in the maternity service and 7 000 000 visits to Vanderbilt Clinic were recorded

Commenting on the hospitals twenty years of achievement in the country's first medical center, Charles F Cooper president noted a stendy increase in all phases of medical research and streased the need for a continuing campaign to obtain endowments for fifty recearch beds. The fifty beds gon for the hospital's twenty-fifth anniversary in 1953 may be endowed he said by individuals clubs associations or companies.

Mr Cooper pointed out that many persons cannot afford the long term hospitalization necessary for research work that may mean improvement and cure. He added "Endowed beds for medical research offer a two-fold opportunity for donors. They make possible a lasting memorial and they give important aid to patients cooperating with vital research projects."

PG Course in Rheumatic Heart Disease

ST FRANCIS Sanatorium for (ardiac Children In Rodyn, Long Island announces a comprehensive postgraduate course in rhoumatic fever and rheumatic heart disease at the Sanatorium from June 1 to June 15 inclusive to be held daily all day except Sunday

This course is designed to give intensive training in the diagnosis and treatment of rheumatic fever and rheumatic heart disease. I articular attention is given to recent advances.

The course consists of informal lectures and discus-

sions supplemented by examination and study of patients demonstrating all clinical phases of rheumatic disease. Part of the time will be devoted to rountgenography and electrocardiography and other laboratory procedures with special emphasis on their practical application. The treatment of acute rheumatic disease will be studied in detail.

Fee for the course is \$75 Attendance is limited. For further information address Rev Mother Superior, F.M.M. St. Frances Sanatorium for Cardiac Children Resiven Long Island. New York

New Handbook of Applied Pharmacology Ready for Distribution

BASED on information derived from years of experience in the treatment of patients and the teaching of medical students in the wards and outpatient department of the Long Island College liospital a new 183-page Handbook of Applied Iharmacology listing more than 600 drugs in recommended decays and prepared during three years of research and conferences with specialists attending at the Hospital, is now ready for distribution

A unique feature of the book is an index of disease as well as the index of drugs, which provides a source of advice to interns, medical students and general practitioners, on medicine to be used in various conditions of disease. The book outlines the dose route of administration and the size and nature of the package of each matural presented All recommendations are based on rational modern therapy and many new drugs and their dosages are listed.

A valuable feature of the book is that chemical and belogic preparations such as vitamins and hor mome are listed under their official chemical names, and followed by the special proprietary names under which pharmaceutical manufacturers market identi

cal preparations.

Conforming with standards established by all of the leading medical colleges today the formulary is the first of its kind to base its doses exclusively on the metric system instead of the apothecary system. This means that a gram is ordered instead of a dram A table of metric dosages with the approximate apothecary equivalents is included in the book.

Members of the Formulary Committee who prepared the volume at the request of the Medical
Board of the Long Island Collego Hospital are Dr
Frederick behrocker a member of the consulting
staff of the Long Island College Hospital and former
assistant elinical professor of medicine at the Long
Island College of Medicine, chairman, and Dr
Arthur W Grace durector of the department of
dermatology and syphilology at the Long Island
College Hospital and professor of chinical derma
tology and syphilology at the Long Island
College of Medicine coorditors of the Hondook, who assembled information from all departmental durectors
of the Hospital to achieve the final result

Hospital Association to Hold Annual Dinner

THE GREATER New York Hospital Association will hold its annual dinner on National Hospital Day, May 12, at the Hotel Commodore, New York City Speakers for the occasion will be Dr Charles Gordon Heyd, New York City, Mr Graham Davis, president of the American Hospital Association, and Miss Helen Hayes, chairman of the Citizens'

Committee on Hospital Careers, which will begin its educational campaign in May in conjunction with the national program of the American Hospital Association and the Advertising Council

Telephone calls in reference to reservations for the dinner should be made to the executive office of the Greater New York Hospital Association, MU 3-6541

NEWS NOTES

At the March staff meeting of St Francis Hospital, Poughkeepsie, Dr Barbara Stimson presented a case of severe compression fracture of a lumbar vertebra A case of carcinoma of the rectum with metastasis to the bladder was presented by Dr Norman Fabian

"The Study and Treatment of Thyroid Disease with Radioactive Iodine" was the subject of the meeting on April 14 of the Hudson River State Hospital staff, in Poughkeepsie Dr Virginia Kneeland Frantz, associate attending surgical pathologist at Presbytenan Hospital and assistant professor of surgery, College of Physicians and Surgeons, Columbia University, was guest speaker

Dr Emanuel Appelbaum, chief of the division of acute infection of the central nervous system, New York City Department of Health, and associate professor of clinical medicine, New York University, College of Medicine, was guest speaker at the February meeting of the Clinical Society of the Long Beach Memorial Hospital

"What Is an Adequate Program for the Treatment of the Mentally Ill?" was discussed by Dr George S Stevenson, medical director of the National Committee of Mental Hygiene, at the meeting in April of the Brooklyn State Hospital Psychiatric Forum

"Nutrition in Relation to Disease" was the subject of Dr Marvin R. Thompson, professor of pharmacology and therapeutics, University of Maryland, chairman of the board of trustees of Columbia University College of Pharmacy, and formerly pharmacologist of the US Food and Drug Administration, as the inaugural address of the Institute of Metabolism and Nutrition at Doctors Hospital of Queens The Institute was held on April 14

Dr Arthur Ferguson, chief attending physician at the heart climic at St Luke's Hospital, Newburgh, has proposed a six-point program to combat rheumatic fever—Speaking at a meeting of the Newburgh Public Health and Tuberculosis Association in March, Dr Ferguson recommended the formation of a local heart association to act either as an independent unit or as a subsidiary part of a lay organization

He also recommended a more adequate "follow-up program of physical defects found in school children"

Postgraduate courses are now being offered at the Memorial Hospital of Queens, according to an announcement by Dr Otto Gitlin, medical director Beginning May 6, a course in "Recent Advances in Clinical Pathology" will be given by Dr Samuel Barland. This will include four sessions, on the first and third Thursdays, from 4 to 5 p M

other courses, which began in April, are "Post-graduate Proctology," given by Dr. A. J. Cantor, "Practical Electrocardiography" by Dr. Norman Shaftel, and "X-Ray in the Diagnosis and Treatment of Arthritis and Related Conditions" by Dr. Jonas Borak.

Plans for the operation of the Brunswick General Hospital, Amityville, were discussed at a meeting in February by members of the staff and 250 doctors from Nassau and Suffolk counties Speakers were Dr C L Markham, superintendent, Dr H. B Hendler, president of the new board of directors, Dr J M Lesnow, treasurer, and Drs Charles C Murphey and George Carlin, Amityville, Dr Miner Hill, Oyster Bay, Dr Horace Ayers, New York City, Dr Sol Schlimbaum, Bay Shore, and Dr Archie M Baker, Lindenhurst

At the March meeting of the staff of Highland Hospital, Bencon, death cases were discussed Dr Arnold Bockar, consulting urologist, of Newburgh, spoke on hematuria

A cancer detection center was opened in March at the Hudson City Hospital The purpose of the center is to find cancer in persons who believe they are in good health. Sponsored by the Columbia County Medical Society, the center will be open for examinations every Monday night. Appointments may be made by telephoning the Hudson City Hospital

The Canastota Memorial Hospital, closed since last August, was reopened in March The hospital has been remodeled

During the four week period of April 26 through May 22 1948 a full-time refresher symposium in opithalmology is being given by the opithalmological and medical staffs of the Mount Sinai Hospital New York Cit; in affiliation with Columbia University This is designed to be an intensive review of modern concepts in the field and consists of clinical, laboratory, and didactic instruction in pathology embryology bacteriology optics surgery and opithalmoscopy

At the March meeting of the Northern Dutchess Health Service Center in Rhunebeck Dr Charles Williams, attending roentgenologist, presented the correlation of x-ray and clinical aspects of chest discass. Discussion was by Dr F A Gagan and Dr O B Esselstyn

'Dermatology in General Practice was the subforce of the February meeting of the staff of Vassar Brothers Hoepital Poughkeepase Speakers were Drs. Lloyd Kest Vladimir Konheim and Louis Lipman

A paper on Control of Respiratory Infections' was presented by Dr Colin MacLeod, professor obsectedology New York University College of Medicine at the March staff meeting of Castle Point Vetarana Hamilton.

Che at the Asacra stan mothing Veterans Hospital.

Dr Edgar Medlar associate professor of pathol cay at Columbia University College of Physicians and Surgeons, lectured on "A Study on the Pathogenesis of Minimal Pulmonary Tuberculosis at the Castle Point Veterans Hospital on April 28

The clinical pathological conferences of Meadow brook Hospital Hempstead, Long Island discontinued during the war, have been resumed with the conferences being held on the fourth Friday of each month at 4 30 r n Physicians wishing to receive conference cases before the meeting are requested to write Dr Theodore J Curphey, Pathological Department, Meadowbrook Hospital, Herapstead, Long Island New York.

Cornell University Medical College is now offering a three-month course in graduate instruction in internal medicine—Beginning April 1 the course was designed to give practical instruction in the subjects of internal medicine neurology, and other medical specialities, including electrocardiography gastroenterology, pulmonary diseases morbid anatomy, clinical medicine and psychosomatic medicine. The instructors are members of the faculty of Cornell University Medical College and the entire teaching facilities of the medical outpatient department of the New York Hospital are available for this work.

Seminars on the trends in maternity and newborn care were held on April 27 and 28 at the Kings County Hospital in Brooklyn Chairmen and their sessions were Dr Charles Weymuller professor of podiatres. Long Island College of Medicine "Toward Better Care of the Newly Born Infant , Dr Morrus Glass president of the Brooklyn Gynecological Society "Toward Better Maternal Care Miss Horiense Hilbert, director of the Bureau of Nursing, New York City Department of Health, Aro We Making the Best Use of Auxiliary Workers!

PERSONALITIES

Elected

To the board of directors of Rochester Hospital Service Dr Ellas B Soble president of the Medical Society of the County of Monroe Dr Elmer W O'Brien and Dr William A. Sawyer Dr G Elmer W G'Brien and Dr William A. Sawyer Dr G Elmer Martin, Troy as president of the Leonard Hospital medical staff As vice-president of the Leonard Hospital, Troy staff Dr Vincent T Lagudara and as secretary treasurer, Dr Ferdinand Haverly Dr W A. Casper of the St. Vincent's Hospital staff Ruchmond to the American Board of Allergists

Appointed

Dr Louis M. Rousselot as director of surgery St. Vincent s Hospital, Now York City, and professor of clinical surgery at New York University College of Medicine. As resident in anesthesn at Presbyterian Hospital, Now York City Dr Gerald Savage, former intern and assistant anesthetist at Staten Island Hospital Dr Cushman D Haagen Sen associate professor of surgery at Columbia University College of Physicians and Surgeons, as coordinator of cancer teaching for the college's cancer research program

Dr Charles C Sweet, reappointed chief of staff of

Ossining Hospital. From the courtesy to the consulting staff of Ossining Hospital Dr J A. Taylor Tarrytown and Dr S H. Nickerson White Plains.

Honored

Dr Cornelius P Rhoades, director of the Memorial Hospital Center for Cancer and Allied Diseases, New York City as recipient of eleventh annual Clement Cleveland award for outstanding work in cancer control during 1947 by the New York City Cancer Committee Dr Alvin Hulnick associate orthopedie attending surgeon at Statem Island Hospital certified as a specialist by the American Board of Orthopedies.

Retired

Dr. Thomas I Price, associated with the New York City Department of Hospitals since 1909 as general medical superintendent of the Department of Hospitals, a position he has held since 1944. He will be succeeded by Dr. Marcus D kogel Dr. Frank L. Babbott, as chairman of the board of trustees of the Long Island College of Medicine Brook lyn to be succeeded by Lauson H. Stone.

ABSTRACT OF MINUTES OF THE COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

T ITS meeting on March 11, 1948, the Council considered the following matters, taking action as indicated

Secretary's Report

Remission of State Assessments -The remission of State assessments was voted on account of service with the armed forces for one member for 1948 and twelve for 1947, also on account of illness for Drs Harry J Hammond, Frederick Washnitzer, William Braunstein, Hugo Schueller, Nathan Schutz, William H Beattie, Lawrence F Drumm, Henry Washeim, Jr., George H Stephens, L M Hickernell, George T Boycheff, and Gerti Doomef. Also the rescinding of one remission of assessment was authorized

Meetings - During your leap year month, it has been your Secretary's privilege mainly to cover such routine matters as answering correspondence and attending committee meetings Honever, on February 16, I spent the day with Dr Dan Mellen, chairman of your Committee on Rural Medical Mrs Virginia Shuler, secretary of the Committee on Rural Medical Service of the American Medical Association, Colonel W L Wilson, Medical Corps of the US Army, and Dr Joseph A Lane, secretary of the Medical Society of the County of Monroe, calling upon Dr A Lembcke and Dr Albert D Kaiser, associate director and executive director, respectively, of the Council of Rochester Regional Hospitals, Inc These gentle-These gentlemen generously explained how their Council was developed, and how it functions under grants from the Commonwealth Fund to assist in the improvement of medical care chiefly through the hospitals in the following eleven counties. Allegany, Chemung, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, and Yates On February 18, with Dr Harry Aranow, I at-

tended a meeting at the Association of the Bar of the City of New York, where the so-called "Silverson Plan" regarding social security for professional and small business people was discussed. The American Medical Association was represented at this meeting by Dr Frank G Dickinson, director of the Bureau of Medical Economic Research, and Mr J W Holloway, Jr, director of the Bureau of Legal Medicine and Legislation The subject in question has been accepted as a responsibility by our national

body and several others

On February 25, your Secretary attended the annual meeting of County Legislative Committee Chairmen in Albany, and on March 1 it was my pleasant duty to represent you at the maugural dinner of the American Academy of Compensation Medicine, Inc. The chairman of the Section on Industrial Medicine and Surgery of the Medical Society of the State of New York, Dr. Harry V. N. Spaulding, is president of the American Academy of Compensation Medicine, Inc. He and Miss Mary Donlon, chairman of the Workmen's Compensation Board, State Department of Labor, delivered the speeches of the evening

What appeared to be the last regular meeting of the Advisory Committee on Workmen's Compensation Fee Schedule was held on February 19 Recommendations are being made to Miss Mary Donlon

Preparations for the Annual Meeting in May are ogressing satisfactorily Most of the Annual progressing satisfactorily

Reports for the House of Delegates have been received at the State Society office

Communications —Letter from Dr E Dean Babbage, president of the Medical Society of the County of Erie, to Dr. Louis II Bauer, President, dated February 20, 1948

The Medical Society of the County of Erie believing that organized medicine should do all within its power to help solve the problems of chronic alcoholism established early this year a new Society agency known as the Special Committee on the Problems of Alcohol which has launched a broad program designed to bring about better medical and institutional care for alcoholics and to create through a campaign of education an ealightened and more cooperative public attitude toward the sufferer from alcoholism. Though several other county medical acqueties in New

Though several other county medical societies in New 1 ork State have set up special committees with similar objectives, the vast majority of county societies so far as we can learn have to date taken no official cognizance of the medical nature of the problems of alcoholism nor have they created special committees to deal aggressively with this question.

question

question

This realization led to the adoption by a unanimous vote
at the February 17 monthly meeting of the Comitia Minora
of the Medical Society of Eric County of a resolution offered
by the chairman of the Society & Special Committee on the
Problems of Alcohol, Dr Milton G Potter This resolution
in substance and purpose respectfully and earnestly petitions the Medical Society of the State of New York to make
the problems of alcoholism a matter of State Society concern,
and further to assume the leadership in stimulating in
creased interest in these problems by all county societies on
their local level their local level

Full text of the resolution, which is forwarded to you at the direction of the Comitia Minora, follows

Whereas all the causes of alcoholism and of compulsive

drinking are not known and
WHEREAS individuals manifesting the complex symptoms of alcoholism and compulsive drinking are sick persons in need of medical care, now, therefore be it
RESOLVED that alcoholism and compulsive drinking be

RESOLVED that alcoholism and compulsive drinking be known as disease complexes to be considered as illnesses and to be dealt with accordingly, and be it further RESOLVED that the Medical Society of the County of Erie and its Special Committee on the Problems of Alcohol the same being a subcommittee of the Society s Committee on Public Health do hereby petition and urge the Medical Society of the State of New York through action by its Council to bring about the appointment of a Special Committee on the Problems of Alcohol of the Medical Society of the State of New York and further that the Council of the Medical Society of the State of New York and further that the Council of the Medical Society of the State of New York be urged to request each component county society in the State to appoint a local special committee on the Problems of Alcohol in association with its work in the field of public health.

It is the sincere hope of the Medical Society of the County of Ene that the foregoing resolution will receive favorable consideration at the hands of the Council of the State Medical Society May the privilege be ours of receiving your reactions to this proposal

After discussion, it was voted that the matter be referred to the Subcommuttee on Mental Hygiene of the Committee on Public Health and Education, with direction to confer with a Committee of the New York Academy of Medicine which has been studying alcoholism

Dr Anderton stated that he had a copy of another letter along the same lines to Governor Dewey from the President of the Medical Society of the County of Eric, advocating the formation of a State commission for the study of alcoholism and other mat-

It was voted to defer action until the Subcommittee on Mental Hygiene reports

Letter from Dr George E Anderson, chairman of the Section on Medicine, under date of March 1, 1948, in regard to the appointment of Dr Thomas H McGavack, 1 East 105th Street, New York City,

as Delegate from the Section on Medicine to the House of Delegates

After discussion at was rotal that Dr. Anderson be informed that he did not have the authority to make an appointment—that the only one that could elset a delegate is the Section itself but that the matter will be referred to the House of Delegates with the suggestion that Dr. McCavack be seated.

Letter from Oneida County Middeal Society dated February 13 1948, in regard to remitting the dues of Dr. Oswald J. McLendree and Dr. Robert C. Hall because of their services as Secretary and Treasurer.

After discussion at was voted that the Secretary write them that the Constitution and Bylaws of the State Society do not permit the remission of dues except for illness

A letter was read from Mrs. Mary C. Brittain dated March 2 1048 acknowledging our letter of sympathy on account of Dr. Robert Brittain's

demise

Letter from Dr George H Clark of Bradenton Beach Florida to the New York NATE JOURNAL or MEDICINE under date of January 27 1948 in regard to the fact that he was not receiving his JOURNAL.

Dr Anderton stated he had communicated with the Medical Society of the County of Monroe and found that Dr Clark had resigned in 1943

It was roted that the Secretary write Dr Clark stating that our records indicated that he rosigned his membership and suggest that he take up the question of being restored to membership with the Medical Society of the County of Monroe

Treasurer a Report was accepted

Report of Executive Officer

Dr Aranow reported that because the Legislature is expected to close soon it was important for Dr Hannon to remain in Albany He stated that Dr Hannon appears to be very well liked by all the legislators, and that all the reports about him are good. Dr Bauer added that the Commissioner of Health had told him that Dr Hannon has been of inestimable help to him.

Reports of Committees

Committee on Legislation—Dr Aranow Chair ran expressed himself as being discouraged at the lack of concerted action on the part of the profession as shown by introducing bills and them withdrawing them on account of objections from certain groups. He also felt that no county society should go over the head of the State Society in appealing to legislators or to the Governor, because such acts weak encd the position of the State Society. He reported that a certain sentence had been overlooked in the drug dispensing bill when it was approved by the County Legislative Chairman and he would like permission of the Council to protest to the Governor that that particular provision had very bad implies those and for that reason it is felt that the bill should not be approved

It was roted that this permission be given

The question of the podiatry bill was brought up by Dr Aranow

It was roted that the Council does not wish to reverse its provious stand which was not to oppose the bill

The bill introduced to register and license psychol-

ogists has been withdrawn because of objections to

Committee on Economics.—Vir Farrell director of the Bureau of Medical Care Insurance made the

following report
On February 18 I received from Associated
Medical Care Plans the following report from a
Subcommittee to Draft Bylaws for the proposed
Blue Cross-Blue Shield Association Dr Aaron
feels this is important.

It is proposed that a National Blue Cross-Blue Shield Association be established and also an in surance corporation (1) to make possible the insuring of national accounts on uniform rates and benefits (2) to establish standard admin istrative regulations (3) to provide Blue Cross coverage in every area of the United States and outside the United States (4) for coordination and direction of all administration through a single agency, (5) for additional benefits coverage and in addition, to establish some method of cooperation with governmental agencies to help provide against costs of medical and hospital care from a national level

The proposed Blue Cross-Blue Shield Association affairs are to be managed by a Board of 20 Governors scheeted as follows: (1) Five persons designated as Hospital Governors (2) Five persons designated as Medical Covernors, (3) Two persons designated as Commission Governors (4) Two persons designated as Medical Association Governors (5) Two persons designated as Hospital Association Governors and (6) Ten persons designated as Public Governors and

The aims and purposes of the Association are perhaps a forward step in meeting the nation as health needs however voluntary non profit medical care plans should remain the responsibility of authorized representatives of the medical profession and not be subject to the domination and control of any organisation or group as proposed

of any organisation or group as proposar. On instructions from Dr Aaron, I attended a meeting in Chicago on March 6 called by a group of intorested parties to discuss this proposal. The meeting had no official standing but about 100 at tended. Two resolutions were presented from the west coast area, one by the Medical Service Bureau of the Utah State Medical Association, and the other by representatives of California Physicians Service Oregon Physicians Service Idaho Physicians Service Oregon Physicians Service, and Utah State Medical Service Bureau opposing the proposal A statement of opinion, also in opposition was presented by the members of Blue Cross plans comprising District 11 which corresponds with the above medical care plans Inquiry was made from the floor if any of these proposals had been submitted to Boards of Directors of any of the plans. The answer was that the boards had not seen the proposal

The question was brought up if it was legal to establish such a corporation As our present Article I's-C stands a nonprofit corporation cannot dispense funds for a national corporation.

dispense funds for a national corporation.

On March 7 the Blue Shikki group held its meeting with five present The purpose of this conference was to formulate a report to be presented to the A M C P convention in Los Angeles the latter part of March

My second annual report to the Subsommittee on Medical Expense Insurance of the Council Committee on Economics on the progress of New York State Voluntary Nonprofit Medical Care Plans follows (Tables 1-11)

TABLE 1 - Comparative Membership Totals for Year Ending December 31 1947

	December 31, 1947	December 31 1946	Increase	Per cent of Increase
United Medical Service Inc. New York	730 293	405 292	325,001	80
Western New York Medical Plan Inc Buffalo Medical and Surgical Care, Inc., Utica	119 708 89 369	100 281 69 247	19 427 20 122	19 29
Central New York Medical Plan Inc., Syracuse	15 322	11,308	4 014	35
Genesee Valley Medical Care Inc., Rochester	46 145	11 914	34 231	287
*Northeastern New York Medical Service Inc Albany	22 778		22 778	
Total	1 023 615	598 042	425 573	71

^{*} Period from December 1 1946 through December 31 1947

TABLE 2 -MEMBERBHIP ACCORDING TO CLASS OF PARTICIPANTS FOR YEAR ENDING DECEMBER 31, 1947

	Subscribers	Dependents	Total
United Medical Service Inc., New York	375 684	854,609	730 293
Western New York Medical Plan Inc Buffalo	47 018	72,690	119 708
Medical and Surgical Care Inc., Utica	43 973	45 396	89 369
Central New York Medical Plan Inc., Syraouse	6 503	8 819	15,322
Genesee Valley Medical Care, Inc. Rochester Northeastern New York Medical Service Inc.,	19 202	20 943	46 145
Albany	9 963	12 815	22 778
Total	502 343	521 272	1 023 615

^{*} Period from December 31 1946 through December 31 1947

TABLE 3 - COMPARATIVE STATEMENT OF TOTAL MEMBERSHIP IN MEDICAL AND HOSPITAL PLANS

	1946			1947				
	Hospital	of Total	Medical	of Total	Hospital	of Total	Medical	of Total
United Medical Service Inc. New York Western New York Medical Plan Inc.	2 788,987	87 32	405 292	12 68	3 206 178	81 45	730 293	18 55
Buffalo	421 115	80 77	100 281	19 23	445,689	78 81	119,708	21 17
Medical and Surgical Care Inc. Utica Central New York Medical Plan Inc.	137 068	66 44	69,247	33 50	146 818	62 17	89 369	37 83
Syracuse Genesee Valley Medical Care Inc	231 021	95 34	11 308	4 66	253 507	94 31	15 322	5 69
Rochester Northeastern New York Medical Ser-	313 491	96 34	11,914	3 66	336 548	87 94	46 145	12 06
vice Inc Albany	182 261				218 927	90 58	22 778	9 42
Total	4 073 943	87 20	598 012	12 80	4 607,667	81 83	1,023 615	18 17

TABLE 4 —Comparative Statement of Membership Inchease in Medical and Hospital Plans

	1946			1947				
	Hospital	of Total Increase	Medical	of Total Increase	Hospital	of Total Increase	Medical	% of Total Increase
United Medical Service Inc. New York Western New York Medical Plan Inc.	585 553	70 58	244,164	29 42	417 191	56 22	325,001	43 78
Buffalo Medical and Surgical Care Inc Utica	54 412 27 890	58 12 50 19	39 221 27 687	41 88 49 81	24 574 9 750	55 85 32 64	19 427 20,122	44 15 67 36
Central New York Medical Plan Inc., Syracuse Genesee Valley Medical Care Inc.,	41 820	86 01	6 808	13 99	22 486	84 86	4 014	15 14
Rochester	42 778	78 22	11 914	21 78	23 067	40 26	34 231	59 74
Northeastern New York Medical Service, Inc. Albany					36 666	61 69	22 778	38 31
Total	752 462	69 53	329 794	30 47	533 734	55 64	425 573	44 36

Comments -"This report is presented to inform you of the progress of the six New York State voluntary nonprofit medical care plans approved by the Medical Society of the State of New York

"Progress on a state-wide basis has been most gratifying Your Director stated in his report for the year ended December 31, 1946, that membership would increase to approximately 1,000,000, and incurred benefits to members and physicians would be approximately \$3,500,000

"Membership increased by 425,573 during 1947, making a total of 1,023,615 at December 31, 1947. This represents the largest membership of any state offering one or more voluntary nonprofit medical care plans. This increase has been due to a better understanding of the plans by the medical profession, an appreciation of the value of the prepayed medical personal medical care plans. prepaid medical care insurance principle, and also a more intensive sales effort on the part of administering organizations It is important that as these

TABLE 5 .-- Amount or Claims* my Contract for 3 har Eyoing December 31 1917

The Mark State To Mark	Surgical Only	In Hospital Surgical	Surgical and In Hospital Medical	Surgical and Medical (Home, Office, and Hospital)	Total:
United Medical Service Inc., New York	\$1 678,568	\$19 087	\$314,235	\$181,272	\$2,194 00\$
Western New York Medical Plan, Inc. Buffalo Medical and Surgical Care, Inc. Utica	345,670 441,360		305,496		654 17 <i>9</i> 441,350
Central New York Medical Plan, Inc. Syraruse	4 649			98,280	102 929
George Valley Medical Cars, Inc. Rochester	100 632				100 632
†Northeastern New Lork Medical Service, Inc., Albany			61 725		61 725
Total:	\$2 573 885	\$19 987	\$581 450	\$279 552	\$3,554,880

TABLE 6 .- NUMBER OF CLAIMS* BY CONTRACT FOR YEAR ENDING DECEMBER 31 1947

	Surgical Only	In-Hospital Surgical	Surgical and In Hospital Medical	Surgical and Medical (Home, Office, and Hospital)	Total
United Medical Service, Inc. New York	28,810	335	5 514	13,903	48,568
Western New York Medical Plan Inc. Buffalo Medical and Surgical Care, Inc. Utica	9 709 18,117		21 743		31 451 18,117
Central New York Medical Plan, Inc. Syracuse	134			9 744	9,878
Genesse Valley Medical Care Inc. Rothester	2 162				2 612
† Northeastern New York Medical Ser vice, Inc. Albany			966		966
Total	50,887	335	28,223	23 647	111,592

TABLE 7 -Average Cost per Claim* by Contract for Year Ending December 31 1947

	Burgical Only	In Hospital Surgical	Surgical and In-Hospital Modical	Surgical and Medical (Home, Office, and Hospital)
United Medical Service Inc. New York	\$58 25	\$50 66	857 00	\$13 03
Western New York Medical Plan, Inc. Buffalo Medical and Surgical Care, Inc. Utica	35 91 24 36		14 05	
Central New York Medical Plan, Inc., Byracuse	34 70			10 08
Genemics Valley Medical Care Inc., Rochester	38 52			
† Northeastern New York Medical Ser vice, Inc., Albany			63 89	

TABLE 8.—CLAIM INCIDENCE FEE 1 000 PARTICIPANTS PER ANNUA BY TYPES OF CONTRACTS* FOR YEAR ENDING DECEMBER 31 1047

Surgical Only	In-Hospital Burgical	Surgical and In Hospital Modical	Surgical a Medical (Home, Office, and Hospital)
	71.40	44.44	
60 77	/1 42	00 30	610 66
124 19		738 70	
210 07			
95 37			728 68
73 62			
		71 29	
	Only 60 77 124 19 219 97	Only Surgical 60 77 71 42 124 19 219 97 95 37	Surgical In-Hospital In Hospital Only Surgical Medical Medical Surgical 124 19 738 70 95 37

Norz, Experience of Medical and Burgical Care Inc. Utica, includes benefits under Medical Call Rider Experience of Western New York Medical Plan Inc., Buffalo includes benefits under Burgical and Medical Contract until March 1 1947 when bome and office calls were discontinued.

^{*} Incurred basis. † Period from December 31 1946, through December 31 1947 ‡ Paid basis.

TABLE 9 -EARNED PREMIUM INCOME TOTAL EXPENSES AND UNDERWRITING GAIN FOR YEAR ENDING DECEMBER 31, 1947

	Earned Premium Income	Total Expenses	07	Gain from Underwriting	%
United Medical Service Inc New York	\$3,986 028	\$3 168 199	79 48	\$ 817 829	20 52
Western New York Medical Plan Inc Buffalo	830 264	7 25,019	90 94	80 648 95 224	9 06
Medical and Surgical Care, Inc. Utica Central New York Medical Plan Inc	621 007	520 843	84 06		15 34
Syracuse Genesce Valley Medical Care Inc	152,488	124 665	81 75	27 823	18 20
Rochester † Northeastern New York Medical Ser-	223,762	136 779	01 12	86 983	38 88
vice Inc Albany	96 058	76 038	79 16	20 018	20 84
Total	\$5 909 665	&4 786 543	80 90	\$1 128 525	19 01

TABLE 10 —Earned Premium Income Claim and Administrative Expense for Year Ending December 31 1947

	Earned Premum Income	Claim J xpense	%	Administrative Expense	%
United Medical Service Inc. New York	\$3 986 028	6 2 320 738	58 22	\$847 461	21 26
Western New York Medical Plan Inc Buffalo	830 264	654 172	50.70	100 846	10.14
Medical and Surgical Care Inc Utica	621 067	441,359	78 79 71 06	84 483	12 14 13 60
Central New York Medical Plan Inc	021 001	41,000	71 00	01 100	15 00
Syracuse	152 488	102 929	67 ა0	21 736	14 25
Genesee Valley Medical Care Inc Rochester † Northeastern New York Medical Ser-	223 762	100 632	4o 00	36 147	16 19
vice Inc Albany	96 056	61 725	64 25	14,313	14 90
Гotal	85 909 665	\$3 681 555	62 30	81 104,986	18 70

NOTE Claim and administrative expense on incurred basis.

TABLE 11—Comparative Statement of Earned Premium Income and Incurred Expenses per Contract and per Member for Year Ending December 31 1947

		Dail Toll Addition	BRIDENIG DECIMA	BEN OF IDE.		
	United	Western	Medical	Central	Genesee	† Northeastern
	Medical	New York	and	New York	Valley	New York
	Service	Medical	Surgical	Medical	Medical	Medical
	Inc	Plan Inc.,	Care Inc	Plan Inc.	Care Inc.,	Service Inc
	Vew York	Buffalo	Utica	Syracuse	Rochester	Albany
Larned Premium Income Per contract Per member Lxpenses Incurred Per contract Per member	\$3 986 028	\$830,264	\$621 067	\$152 488	8233 762	\$96 056
	12 34	19 31	15 26	25 72	13 31	16 58
	6 30	7 58	7 53	10 74	3 66	7 23
	847 461	100 840	84 483	21 736	36 147	14 313
	2 62	2 34	2 07	3 66	2 15	2 47
	1 35	0 92	1 02	1 53	0 91	1 07

Note Mean averages used in determining contracts and membership

plans progress, ways and means be adopted whereby everyone eligible to enroll may be given an opportunity to do so for himself and his dependents

"In considering the growth of these plans during the past two years, it is reasonable to anticipate that membership will increase during 1948 to approvimately 1,500,000 and that incurred benefits to physicians and members will be approximately \$5,400,-

"All plans are now submitting to the Bureau quarterly reports which are analyzed as to membership, claim cost, and incidence of demand, administrative

cypense, reserves, and surplus
- "Looking forward to a uniform contract on a statewide basis, the data and information regarding experience of different types of contracts, in addition to the data items listed above, will be invaluable in determining the type of contract most practical and which will meet the needs and desires of the public, be actuarially sound, and protect the interests of the subscriber and physician

"We have attempted to present our report in a manner which will be readily understandable Comments and questions regarding any part of the report will be welcome"

Malpractice Insurance and Defense Board -Dr Anderton reported that the Malpractice Insurance and Defense Board met March 9 until twelve midnight and discussed their annual report and other matters

Committee on Medical Service -Dr Aranow reported that the Society had sent him a letter from the American Association of Blood Banks, Dallas, Texas, asking endorsement by our Society Aranow did not feel that the information was complete enough, and the Secretary was requested to obtain more specific information

Committee on Public Health and Education -

Dr Mitchell reported as follows
February 25, 1948 In Albany to attend the annual conference of county society legislative

charmen with Committee on Legislation

March 10, 1948 In New York City to attend a
conference of the Council Committee on Public Health and Education and the Subcommittee on Child Welfare, with representatives of the New York State Association of School Physicians and the State Department of Education and Health to Also present were consider school health services

some of the officers of the Medical Society of the State of New York.

A request was received from the New York State Division of the American Cancer Society for a list of 1948 Chairmen of Cancer Committees in the county medical societies Letters have been sent to the secretaries of the county medical societies requesting this information which, when received, will be sent to the New York State Division of the American Cancer Society

Postgraduate Education Postgraduate instruction has been completed in Cortland, Franklin, St. Lawrence, Suffolk Sullivan and

Ulster countles

Postgraduate instruction is being presented in the following countles Cayuga Clinton Madison, Onondaga, Ontario Richmond Schenectady and

Tompkins

Copy of the Teaching Day program for Tucsday May 18 1948, at the Annual Meeting, was sub-A request has been received from the Nassau

County Medical Society for a scries of three lec-

Committee on Public Relations.—Dr Winslow

chairman presented the following report

The Public Relations Bureau mailed to state officers, county presidents and county legislative chairmen of the Woman's Auxiliary four specially prepared bulletins dealing with the Auxiliary and the work it can do to assist the Society in its public relations These were mailed at five-day intervals The fifth bulletin was a special one calling attention to bills introduced at the request of the Society One bill would abolish the Medical Practice Com mittee and another would define the taking and interpreting of x rays as the practice of medicine.

A newspaper release was sent to the daily papers in New York State based upon the editorial in the March I issue of the New York State Journal or Medicane entitled 'State Medical Journal Takes

Stand Against Chiropractors Bill

The following postgraduate sessions held under the auspices of the Committee on Public Health and Education were covered by releases to the press Clinton Cortland, Franklin, Jefferson Ontario Richmond, St. Lawrence, Sullivan and Tompkins counties A Teaching Day was held for Suffolk County

The list of Woman's Auxiliary members was augmented by 201 additional stencils making a

total mailing list of 3 500

Mr Anderson, Mr Walsh, and Mr Miebach

attended the meeting of legislative chairmen in Albany on February 25 Committee on Publication —Dr Losmak, chair man, reported that the Publication Committee held its regular monthly meeting on March 10, 1948 and that the greater part of the time was taken up with the discussion of the supplementary report which the Committee wishes to make to the House of Delogates Throughout the month there had been several meetings of the editorial group to discurs editorial policy

Committee on Rural Medical Service -Dr

Mellen chairman reported as follows

With the Secretary we spent Monday, February 16 1918, in Rochester, learning about the development of the Regional Hospital Plan of the Council of Rochester Regional Hospitals Mrs Virginia Shuler secretary of the Committee on Rural Medi cal Service of the American Medical Association and Colonel W. L. Wilson Medical Corps of the U.S Army and Dr Joseph A Jane, secretary of the Medical Society of the County of Monroe, attended the conference with Dr Paul A. Lembeke, associate director and Dr Abert D Laiser, execu

tive director

We learned that the Commonwealth Fund, in 1944, decided to finance this Regional Hospital Plan with grants of \$75 000 a year for five years to be supplemented by \$10 000 per year from the Rochester Community Chest The Commonwealth Fund also allotted \$200,000 per year for capital outlay for small community hospitals. The Commonwealth Fund may continue the plan, except capital grants for five additional years with lesser grants. Com mencing with the hospitals in seven counties in 1916 the plan was expanded in 1948 to include the hospitals in the Regional Unit, as adopted by the New York State Joint Hospital Survey and Planning Commission The counties are Allegan, Steuben, Chemung, Schuyler Seneca, Vates, Ontario Liv

ingston Orleans Monroe and Wayne

The organization of the Rochester Regional
Hospital Plan consists of the Board of Directors having one member from the public in each county and two members from the Governing Board of each of the twenty four participating hospitals. The policies as enunciated by this Board of Directors are put into effect by (1) The Medical Conference, made up of two members from the medical staff of each participating hospital, (2) the Executivo Staff, and (3) the Administrators Conference "The program that has been put into effect in-

cludes (1) Capital grants which will encompass building programs in about 15 hospitals (2) Educational efforts which (a) sock to have interns or assistant residents rotate from the hospitals in Rochester to outlying hospitals such as those at Corning Geneva Canandalgua and Hornell (b) monthly clinical staff conferences with visiting leaders (c) teaching institutes at strategic points (d) courses at Rochester hospitals, (e) medical followships—Rochester and elsewhere (f) courses for nurses in Rochester and special courses elsowhere and (p) hospital administration instruction at University of Rochester, and (3) Direct services to outlying hospitals e.g. central purchasing.
The planning and execution of this regional

experiment to improve medical care in the smaller communities of a specific region has been carefully and skillfully executed. Being a human endeaver it has not clicked one hundred per cent However, it affords an example which may well be emulated

elsewhere throughout the country

Committee on Lisison with Veterans Administra tion.-Dr Anderton stated Dr Bauckus chairman. had written under date of March 4 1948 as follows

I should like very much to attend the Council meeting on March 11 but because of a vacation I shall not be able to come to New York for that date

I should like to report that on February 20 1918 the Acting Branch Medical Director advised Man agers of all VA installations as follows

For your guidance and information, the follow ing is quoted from a letter of the Chief Medical

Director dated February 13, 1918

It is believed that all cares where the \ A authorizes treatment it should be paid for by the Government The more fact that the veteran is also a physician is incidental as he is not paying the bill. The authorization of treatment and payment therefore is a responsibility placed upon the V \ by law A M Kleinman, M D Acting Branch Medical Director

"Dr Lull, secretary of the American Medical Association, writes me that Dr Magnuson has recently met with some of the trustees and stated that one of the serious problems confronting him is the proper staffing of the outpatient clinics. I quote from his letter

Dr Magnuson would like to have help from the local medical societies in staffing these organirations Physicians who are qualified could be appointed and could serve on an hourly basis a specified number of days a week. They would be appointed in grades commensurate with their professional ability. The veteran who desires treatment from his family physician will still contimue to get it Dr Magnuson is not particularly happy with the staffs in a great many of the out-patient clinics and would like to have them built This will take the cooperation of local medi-Some of the full time physicians who now operate these outpatient clinics can be assigned to smaller hospitals

Dr Magnuson further stated that the majority of the paper work would be done by permanent

employees

"I believe that where such appointments are made that the personnel selected should be the best ob-If one sentence of the quoted paragraph applies I do not think it will be necessary to appoint I refer to this such staffs in increasing numbers

The veteran who desires treatment from his family physician will still continue to get it

"It may not be the case in other states, but in New York State I feel that there has been a great trend to direct treatment away from the private practicing physician The policy in different states seems to vary greatly according to the desires of the I think that the Veterans state branch director Administration should have a more uniform policy for all of the states so that certain veterans in one part of the country are not denied certain opportunities and rights granted to those in other areas

"As you recall, several months ago the Veterans Administration set forth a policy that part-time medical men who resigned from their part-time services would not be allowed to take care of veterans under the private medical care plan for a period of two years unless the physician in question removed to some distant part where he was not known They also made efforts to keep part-time physicians from practicing private medicine where veterans were concerned. I did not expect that they would privately take care of veterans whom they had seen in their clinics but we did hope that the original free choice of physician by the veterans would not be violated These limitations and restrictions, which I construe as an unwarranted interference with the private practice of medicine and which is in my opinion a violation of the contract we have here in New York State, have more and more made physicians reluctant to go into the Veterans Administration on a part-time basis It has been stated to me by one of their top officials in New York State that denying the private practice opportunity to the part-time physician would tend to keep him in line with the Veterans Administration clinic and authority I do not like these implica-

"I think it is pertinent to point out now that, after all, our care is limited to service-connected disabilities or disease and that the nonserviceconnected medical problems are for the VA person-Expansion of this nonservice-connected care may result in unlimited medical care for the veteran and his family I believe that if nonservice care is given by the government outside the hospital that it should be done by the private practicing physician I know that certain Veterans Administration administrators would like to expand all

"I should like to report that under the Veterans Medical Service Plan of New York, Inc., we are still giving a great deal of medical service to the veterans. I feel that this is mostly so because they do not have enough personnel in the VA to take care

of the needs

outpatient clinics

"I shall appreciate it if you will convey this message with my respects to the Council at its meeting of March 11"

Committee on Workmen's Compensation -Dr Kenney, Chairman, presented the following report

Arbitrations — Arbitration proceedings for the counties of Montgomery, Fulton, Albany, Saratoga, Schenectady, and Rensselaer will be held in Albany at the Hotel Dewitt Clinton on Friday, March 19, 1918 the properties of the Albany County of 1948, through the cooperation of the Albany County Medical Society

Arbitrations were held in the city of Newburgh for the counties of Orange, Dutchess, Rockland, and Sullivan on Wednesday, February 18, 1948 The arbitrations were held in St Luke's Hospital through the cooperation of the Orange County

Medical Society

Impartial Specialists for Directory —On February 19, 1948, after having received a Directory card from a physician who stated that she was an impartial specialist under the Workmen's Compensation Law (Section 13(d)), we addressed a letter to the char-man of the Workmen's Compensation Board requesting information as to physicians who had been appointed to these positions To date we have received no reply

Medical Bureau License Refused —The Medical Society of Jefferson County, after due consideration, refused to recommend a medical bureau license for the New York Air Brakes Company plant in Water-

town, New York

The employer has appealed to the Medical Appeals Unit of the Industrial Council and the president of the Medical Society of Jefferson County has requested your Director to appear for the Society at

the time of the appeal

Changes in Medical Reports —We have been informed by the Compensation Insurance Rating
Board that the Workmen's Compensation Board is making changes in medical reports, but thus far our advice or opinion has not been requested, nor have we been informed as to the nature of the changes

Workmen's Compensation Law - Chapter 756, Lows of 1947, effective July 1, 1947, was amended (Section 13-f(1) Workmen's Compensation Law), to provide that a claimant who pays to a physician a fee for medical services that the insurance carrier should pay, may assign to the chairman of the Workmen's Compensation Board a cause of action against a physician in trust for the claimant

In Referee Bulletin No 23, issued by the charman of the Workmen's Compensation Board to referees, examiners, and compensation clerks, the chairman asks that whenever it is learned a claimant has paid a physician for compensable medical care,

the matter should be promptly referred to the office of the chairman 'if an authorized physician fails after notice to make prompt refund to the claimant appropriate action will be taken.

The chairman then makes the following additional statement, "Where a physician is unauthorized the claimant will be advised that he may assign his cause of action to the chairman by executing an assignment in form designated for that purpose, such assignment should then be referred to the office of the general counsel."

It was voted that the matter of unauthorized physicians not being entitled to be paid by the injured workman be referred to Counsel of the State Society for an interpretation of the law so that Dr. Kenney may take appropriate action

New Business.-Dr Dattelbaum stated he had received information that the H.I.P were sending patients not to their groups but to the doctors offices and he felt that this violated the principle of free choice. Dr Aranow suggested that Dr Dattel baum write to Dr Dean Clarke about this objection, as the matter was being discussed by the HIP at

World Medical Association.—Dr Bauer stated that the Council of the World Medical Association will meet here in New York the last week in April The United States Committee is tendering them a dinner one evening when they are here This is the first time this international group has met in New York or in this country, and he wondered whether the State Society would wish to consider giving a dinner just to the members of the Council and their wives while they are here. The United States Committee is giving a dinner not only to them, but is also inviting the ambassadors and consuls of the countries concerned.

After discussion it was soled that the Council recommend to the Trustees an appropriation not to exceed \$500 for defraying the expenses of such a dinner for the Council of the World Medical Association with the understanding that any members of the State Society and of the Council who are invited will pay their own way

REFRESHER COURSE IN MEDICINE AT CITY HOSPITAL

City Hospital announces that the next refresher course will be given from May 3, 1948, through June 4 1948 The hours are Monday Wednesday and Friday mornings and Tuesday and Thursday afternoons. Classes are held at the Welfare Island Dispensary

The course is a comprehensive review in internal medicine and the allied specialties designed to meet the needs of the general practitioner. The subjects the needs of the general practitioner. The subjects include allergy cardiology, diabetes diagnosis, restroenterology hematology, peripheral vascular disease, and pulmonary disease. Emphasis is placed throughout on the diagnosis and treatment of the disorders commonly encountered in general practice

The newer diagnostic and therapeutic procedures are described and evaluated in the light of clinical experience Students are also permitted to make rounds on the wards of City Hospital by special arrangement.

There is no tuition fee. Request for applications should be addressed to Dr Milton B Rosenblatt, Welfare Island Dispensary, 80th Str End Avenue New York 21 New York. 80th Street and East

BOOKS

Books for review should be sent to the Book Review Department at 1313 Bedford Avenue Brooklyn N Y Acknowledgment of receipt will be made in these columns and deemed sufficient notification. Selection for review shall be based on merit and interest to our readers

RECEIVED

History of Medicine A Correlative Text, Arranged according to subjects By Cecilia C Mettler, Ph D Edited by Fred A. Mettler, M D Octavo of 1,215 pages, illustrated Philadelphia, Blakiston Co, 1947 Cloth, \$8 50

Illustrations of Regional Anatomy By E B Jamieson, M D 7th ed In seven sections I Central Nervous System II Head and Neck. III Abdomen. IV Pelvis V Thorax. VI Upper Limb VII Lower Limb Large Duodecimo 320 plates Baltimore, Williams & Wilkins Co, 1947 Board, \$3 50 each section.

Cornell Conferences on Therapy Volume 2 Editorial Board, Harry Gold, M.D., Managing Editor Duodecimo of 354 pages, illustrated New York, Viacmillan Co., 1947 Cloth, \$3.75

English-Spanish Chemical and Medical Dictionary Comprising Terms Employed in Medicine, Surgery, Dentistry, Veterinary, Biochemistry, Biology, Pharmacy, Allied Sciences, and Related Scientific Equipment. By Morris Goldberg Octavo of 692 pages New York, McGraw-Hill Book Co, 1947 Cloth, \$10

An Atlas of Anatomy By J C Boileau Grant, M B (Eng) By Regions Upper Limb, Abdomen, Perincum, Pelvis, Lower Limb, Vertebrae, Vertebral Column, Thorax, Head and Neck. Quarto of 496 pages, illustrated Baltimore, Williams & Wilkins Co, 1947 Cloth, \$10

Handbook on Fractures By Duncan Eve, Jr, M D, in collaboration with Trimble Sharber, M D Octavo of 263 pages, illustrated. St Louis, C V Viosby Co, 1947 Cloth, \$5.00

The 1947 Year Book of General Medicine Edited by George F Dick, M D, J Burns Amberson, M D, George R Minot, M D, et al Duodecimo of 784 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth \$3.75

Ulcer The Primary Cause of Gastric and Duodenal Ulcer Diagnosis, Medical and Surgical Treatment, Prevention By Donald Cook, M D Octavo of 187 pages, illustrated Chicago, Medical Center Foundation and Fund, 1946 Cloth, 85 00

Nursing in Modern Society By Mary Ella Chayer, R N Octavo of 288 pages New York, G P Putnam's Sons, 1947 Cloth, \$4 00

140 Million Patients By Carl Malmberg Duodecimo of 242 pages, illustrated New York, Reynal & Hitchcock, 1947 Cloth, \$2.75

400 Years of a Doctor's Life Collected and Arranged by George Rosen, M D., and Beate Caspari-Rosen, M D Octavo of 429 pages New York, Henry Schuman, 1947 Cloth, \$5 00

Facing the Facts About Cancer By Dallas Johnson, for the National Cancer Institute and the American Cancer Society Octavo of 30 pages, illustrated New York, Public Affairs Committee, 1947 Paper, \$0.20

Kurze Klinik der Ohren-, Nasen- und Halskrankheiten By Dr Erhard Lüscher Octavo of 513 pages, illustrated Basel, Switzerland, Benno Schwabe & Co (New York, Grune & Stratton), 1948 Cloth, 54 fr

Dermatology in General Practice By Sigmund S Greenbaum, M D Quarto of 889 pages, illustrated Philadelphia, F A Davis Co , 1947 Cloth, \$12

What to Do Until the Psychiatrist Comes By Norman Anthony Octavo of 150 pages, illustrated New York, Duell, Sloan & Pearce, 1947 Cloth, \$2 50

Jaundice Its Pathogenesis and Differential Diagnosis By Eli Rodin Movitt, M D Octavo of 261 pages, illustrated New York, Oxford University Press, 1947 Cloth, \$6 50

The Foot and Ankle Their Injuries, Diseases, Deformities and Disabilities By Philip Lewin, M D Line drawings by Harold Laufman, M D 3rd ed Octavo of 847 pages, illustrated Philadelphia, Lea & Febiger, 1947 Cloth, \$11

Diseases of the Nose, Throat and Ear By Wilham Lincoln Ballenger, M D, and Howard Charles Ballenger, M D, assisted by John Jacob Ballenger, M D 9th ed Octavo of 993 pages, illustrated Philadelphia, Lea & Febiger, 1947 Cloth, \$12.50

Unipolar Lead Electrocardiography Including Standard Leads, Unipolar Extremity Leads and Multiple Unipolar Precordial Leads By Emanual Goldberger, M D Octavo of 182 pages, illustrated Philadelphia, Lea & Febiger, 1947 Cloth, \$400

A Primer of Cardiology By George E Burch, M D, and Paul Reaser, M.D. Octavo of 272 pages, illustrated Philadelphia, Lea & Febiger, 1947 Cloth, \$4 50

Synopsis of Neuropsychiatry By Lowell S Selling, M D 2nd ed Duodecimo of 561 pages, illustrated St Louis, C V Mosby Co, 1947 Cloth, \$6.50

Smoke-Screen By Samuel B Pettengill Octavo of 126 pages New York, Southern Publishers (Distributors, New York, America's Future), 1940 Cloth, \$1,00

New Fields of Psychiatry By David M Levy, M D Octavo of 171 pages New York, W W Norton & Co, 1947 Cloth, \$2 75

Blood Derivatives and Substitutes. Preparation, Storage, Administration and Clinical Results Including a Discussion of Shock, Etiology, Physiology, Pathology and Management. By Charles Stanley White, M.D., and Jacob Joseph Weinstein, M.D. Octavo of 484 pages, illustrated Baltimore, Williams & Wilkins Co., 1947 Cloth, \$7.50

The Practice of Mental Nursing By May Houliston, R.M.N (Eng.) Duodecimo of 164 pages Baltimore, Williams & Wilkins Co., 1947 Cloth, \$2.75 Principles of Human Physiology (Starling's) By C Lovatt Evans, D.So. The chapters on the special senses by H Hartridge M D 9th Ed. Octavo of 1,155 pages, illustrated Philadelphia, Lea & Fobiger 1946 Cloth, \$10

Textbook of Human Physiology By William F Hamilton, Ph D Octavo of 501 pages, illustrated Philadelphia, F A Davis Co 1947 Cloth \$6.00

The Medical Clinics of North America. Philadelphia Number November, 1947 Index 1945-1947 Octavo Philadelphia W B Saunders Co 1947 Published Bi-monthly (6 numbers a year) Cloth \$10 net, Paper \$12 net.

Petticoat Surgeon. By Bertha Van Hoosen Octavo of 324 pages Chicago Pelk grini & Cudaby, 1947 Cloth, \$3 75

Planning for the Care of the Chronically III in New York State Some Medical-Social and Institutional Aspects. By the New York State Health Preparedness Commission Quarto of 127 pages, Illustrated Albany New York State Joint Hospital Survey and Planning Commission 1947

Biochemistry for Medical Students. By William Veale Thorpe, Ph.D. 4th ed. Octavo of 496 pages illustrated. Baltimore Williams & Williams Co.

1017 Cloth, \$5 00

Congenital Malformations of the Heart. By Helen B Taussig M D Quarto of 618 pages illustrated Nen York, Commonwealth Fund 1947 Cloth \$10

Psychopathology and Education of the Brain-Injured Child. By Alfred A Strauss and Laura E Lehtinen. Octavo of 206 pages, illustrated Now York, Grune & Stratton, 1947 Cloth \$500

Gynecological and Obstetrical Urology By Houston S Everett, M D 2nd ed Octave of 530 pages illustrated. Baltimore Williams & Wilkins Co 1947 Cloth, 80 00

Polsons. Their Isolation and Identification. By Frank Bamford, B So. 2nd ed. Revised by C P Stewart, M.So. Ostavo of 304 pages illustrated Philadelphia, Blakiston Co. 1947. Cloth \$5.00

Your Alling Prostate Gland and What to Do. By Abraham Strachstein, M.D. Octavo of 32 pages, illustrated Girard Kansas E Haldeman-Julius 1947

Stones in the Urinary System By Abraham Strachstein M.D Octavo of 32 pages Girard, hansas, E. Haldeman-Julius 1947

Teaching Psychotherspeutic Medicine An Experimental Course for General Physicians. Given by Walter Bauer M D Douglas D Bond M D Henry W Brosin, M.D. et al. Edited by Helon Leiand Wilmer, Ph.D. Octavo of 404 pages, filturated. New York, Commonwealth Fund 1947 Cloth, \$3.75

American Medical Research Past and Present By Richard H Shryock Ph.D Octavo of 350 pages. New York Commonwealth Fund, 1917 Cloth 8250

The Veterans Administration Rating Board Racket. By Matthew A. Liotta, M. D. Duodecimo of 94 pages New York, J. J. Cavanagh 1947 Cloth \$2.00

The Essentials of Electrocardiography By William L. Gould, M D. Quarto of 2 pages illustrated. Albany The Author 1947 \$2.50

History of the Medical Society of the County of Westchester 1707-1047 By the Medical Society of the County of Westchester Laurence D Redway, Historian A Compilation from the Available Minutes of the Society and Various Contemporary Sources Octavo of 193 pages. White Plains New York The Society, 1947 \$2.50

Medicine as a Profession. Talks with Medical Students. By George Honry Murphy, M.D. Duodeemto of 74 pages. Toronto Ryerson Press. 1040 Cloth, \$1.50

Applied Medical Bacteriology By Max 8 Mar shall, Ph D., with the collaboration of Janet B Gunnison M.A., Alfred S. Lazarus Ph.D. Ellisabeth L. Morrison, M.A. and Marian C. Shevky A.B. Octavo of 340 pages illustrated. Philadelphia, Lea & Febigor, 1947 Cloth, \$4.50

A Textbook of Pathology An Introduction to Medicine By William Boyd, M.D 5th ed Octavo of 1049 pages illustrated. Philadelphia Len & Febigor 1047 Cloth \$10

Reconstructive and Reparative Surgery By Hans May M D Quarto of 964 pages, illustrated. Philadelphia, F A. Davis Co 1947 Cloth, \$15

Diseases of the Joints and Rheumatism By Iremoth Stone, M D Octavo of 362 pages illustrated. New York, Grune & Stratton, 1947 Cloth \$6.50

Child Offenders. A Study in Diagnosis and Treat ment. By Harriet L. Goldberg, Th. D. Octavo of 215 pages New York, Grune & Stratton, 1948 Cloth \$4.00

Diabetes Mellitus in General Practice By Arthur R. Colwell M.D. Octavo of 350 pages illustrated Chicago Year Book Publishers 1947 Cloth \$5.25

Sexual Behavior in the Human Male. By Affred C Kinsey Se D Wardell B Pomeroy and Clyde E. Martin. Octavo of 801 pages, illustrated Phila delphia, W B Saunders Co 1948 Cloth \$6 50

What You Can Do for High Blood Pressure. By Peter J Steincrohn, M D Duodecumo of 101 pages. Garden City, New York Doubleday & Co 1047 Cloth, \$2.50

Treatment of Some Chronic and "Incurable" Diseases. By A T Todd M.B (Edin.) 2nd ed Octave of 324 pages. Baltimer Williams & Wilkins Co 1947 Cloth, \$700

Medicine. By A. E. Clark Kennedy M.D. Vol 1 The Patient and His Disease Octavo of 383 pages Baltimore Williams & Wilkins Co 1947 Cloth 36 00

Experimental Air-Borne Infection. By Theodor Rosebury With the co-authorhilp and assistance of the staff of the Laboratories of Camp Detrick, Maryland Octavo of 222 pages, Illustrated Baltimor Williams & Wilkins Co. 1947 Cloth \$400 (Microbiological Monographs Official Publication of the Society of American Bacteriologists)

Atlas of Bacteriology By R. Cranston Low M D, and T C Dodds Octavo of 168 pages illustrated Baltimore, Williams & Wilkins Co 1947 Cloth 38.50

Psychotherapy in Child Guidance. By Gordon Hamilton. Octavo of 340 pages. New York, Columbia University Press 1917 Cloth, \$4 00

Public Health Administration in the United States. By Wilson G Smillie M D 3rd ed Octavo of 637 pages illustrated. New York, Macmillan Co 1947 Lioth 35 50

Histopathologic Technic. By R. D Lillie M D

Octavo of 300 pages Philadelphia, Blakiston Co , 1948 Cloth, \$4.75

Modern Cosmeticology By Ralph G Harry 3rd ed Octavo of 515 pages, illustrated Brooklyn, Chemical Publishing Co., 1947 Cloth, \$12

Advances in Military Medicine Made by American Investigators Working Under the Sponsorship of the Committee on Medical Research [Office of Scientific Research and Development] Edited by E C \u2214\

George Crile, an Autobiography Edited by Grace Crile Octavo of 624 pages, illustrated Philadelphia, J B Lippincott Co, 1947 Cloth, \$10 set.

Endocrine Therapy in General Practice By Elmer L Sevringhaus, M D 6th ed Octavo of 264 pages, illustrated Chicago, Year Book Publishers, 1948 Cloth, \$4 00

Psychiatric Research Papers Read at the Dedication of the Laboratory for Biochemical Research, McLean Hospital, Waverley, Massachusetts, May 17, 1946 By Cecil K. Drinker, M.D., Jordi Folch, M.D. Stanley Cobb, M.D., et al. Octavo of 113 pages, illustrated Cambridge, Harvard University Press, 1947 Cloth, S200 (Harvard University Monographs in Medicine and Public Health)

A Program for the Care of the Chronically III in New York State By New York State Commission to Formulate a Long Range Health Program, also known as New York State Health Preparedness Commission Quarto of 109 pages, illustrated New York, New York State Commission to Formulate a Long Range Health Program, 1947

[N Y State J M

Case Histories in Clinical and Abnormal Psychology Edited by Arthur Burton, Ph D, and Robert E Harris, Ph D Qctavo of 680 pages, illustrated New York, Harper & Bros, 1947 Cloth, \$400

Medicine Today The March of Medicine, 1946 The New York Academy of Medicine Lectures to the Laity New York, Columbia University Press, 1947 Cloth, \$2 00

The Industrial Environment and Its Control By J M DallaValle Octavo of 225 pages, illustrated New York, Pitman Publishing Corporation, 1948 Cloth, \$4 50

Illustrative Electrocardiography By Julius Burstein, M.D., and Nathan Bloom, M.D. 3rd ed Octavo of 309 pages, illustrated New York, D. Appleton-Century Co., 1948 Cloth, \$6.00

Prophet in the Wilderness The Story of Albert Schweitzer By Hermann Hagedorn. Octavo of 221 pages, illustrated New York, Macmillan Co, 1947 Cloth, \$3 00

REVIEWED

Clinical Pediatrics By I Newton Kugelmass, M D Second edition Octavo of 409 pages New York, Oxford University Press, 1947 Cloth, \$4 00 (Oxford Medical Outline Series)

This is a compact classification or digest of pediatric entities. Symptomatology, treatment, pathology, are all given in a concentrated form. For anyone interested in time-saving, this little book will answer the purpose. This reviewer is not overenthusiastic over any opus that features pediatrics in a predigested form, even if it does save time.

Communal Sick-Care in the German Ghetto By Jacob R Marcus, Ph D Octavo of 335 pages Cincinnati, Hebrew Union College Press, 1947 Cloth, \$4 00

This book contains interesting facts of Jewish history. It traces the roots that lead to the development of the modern hospital. One will better appreciate the modern methods of caring for the sick after reading of the crude and inefficient way the sick and helpless were cared for only a few centuries past. The author traces the close relationship that existed between the Jewish religion and its obligation to the sick and needy destitute. This book should be read with interest by all thinking people.

HARRY APFEL

Nutritional and Vitamin Therapy in General Practice By Edgar S Gordon, M D Third edition Octavo of 410 pages Chicago, Year Book Publishers, 1947 Cloth, \$5 00

This is an excellent summary of vitamin informa-

tion brought up to date. The especially valuable feature of the volume is the sound critical analysis of the literature. Every practitioner, surgeon, or medical man will profit from a careful reading of this book.

ANDREW BABEY

Advances in Internal Medicine Volume II Edited by William Dock, M.D., and I. Snapper, M.D. Octavo of 642 pages, illustrated New York, Interscience Publishers, 1947 Cloth, \$950

Drs Dock and Snapper have assembled in this volume a superb collection of articles on recent advances in internal medicine. Almost every aspect of this wide specialty has been covered, in each case by a man distinguished for original work and ability to teach. All the contributions are good but easily the best is the extraordinary and modestly misnamed article by John McMichael on "Circulatory Failure Studied by Means of Venous Catheterization," Actually, it is a brilliant discussion of a modern viewpoint on what is now called "heart failure". It is essential reading for all internists who wish to keep abreast of the latest developments in cardiology.

MILTON PLOTZ

A Synopsis of Surgical Anatomy, By Alexander Lee McGregor, M Ch (Edm) Sixth edition Duodecimo of 714 pages, illustrated Baltimore, Williams & Wilkins Company, 1946 Cloth, \$650

As in previous editions, this anatomico surgical text of some 600 well-written pages, replete with clarifying illustrations and sketches, has been divided

into (1) "Anatomy of the Normal and (2) "An atomy of the Abnormal. The author once again has skillfully correlated basic and important anatomic data with practical clinical considerations. The book is therefore not merely a text on surgical anatomy per se Clinical syndromes have been clarified in the light of the oscential surgical anatomy and exhaustive details have been happily left to standard texts of anatomy. The diction is precise and clear

Except for relatively minor revisions and ad ditions this sixth edition is not significantly or materially different from the fifth and, like the preceding editions, should be helpful to the aspiring surgeon.

ARTHUR GOETSCH

May's Manual of the Diseases of the Eye. For Students and General Practitioners. Revised and Edited by Charles A. Perora M D Ninteenth edition. Duodoctimo of 521 pages illustrated Battimore, Williams & Wikins Co 1947 Cloth \$4.00

This edition contains considerable new material. Among the additions, sections are included on recent advances in our understanding of congenital catar act, exophthalmus related to the thyroid gland discussion of penicillin therapy various theoretical topics including recont ideas on color vision and a number of new illustrations. This edition has main tained the high standards set by Dr. May and will, no doubt meet with the usual popular recoption.

JOHN N EVANS

Recent Progress in Hormone Research Proceedings of the Laurentian Hormone Conference Edited by Gregory Pincus 8c.D Vol I Octavo of 399 pages illustrated Now York, Academic Press 1946 Cloth, \$7 50

This book is replete with recent experimental research in endocrinology for digestion by people interested in hormones ferments and their clinical application. The papers and discussion of the Laurentian Hormone Conference in 1945 are presented. The discussors are top men in these fields. The book lends itself to careful perusal by the clinician and physiologist especially those who are interested in the newer aspects of this field.

BERNARD SELIOMAN

The American Illustrated Medical Dictionary A Complete Dictionary of the Terms Used in Medicia Surgery, Dentistry Pharmacy Chemistry, Nursing, Veterinary Science Biology Medical Biography etc., with the Pronunciation, Derivation, and Definition. By Lt. Col. W A. Nowman Dorland, M.R.C. (USA) With the collaboration of E. C. L. Miller M.D. Twenty-first edition. Octavo of 1 600 pages illustrated. Philadelphia W. B. Saunders Co. 1947 Flexible Cloth, \$3.00 with Thumb Index \$3.50

The 21st edition of Dorland's great dictionary has many new terms which will make the book more valuable than ever Especially interesting are those concerning radioactive isotopes antibiotics, enzymes and aviation mediane. The book is well printed and neatly bound

ANDREW BADET

Infant Nutrition A Textbook of Infant Feeding for Students and Practitioners of Medicine By P C Jeans M D and Williams McKim Marriott

M D Fourth celition. Octave of 516 pages illustrated St Louis C V Mesby Co 1917 Cloth \$6 50

The three former editions have already established this work as a valuable contribution to the library on infant feeding and the sciences dealing with the functions of the digestive system and metabolism. The reader will find the clapters on 'Malautrition and Durrhes of especial interest.

HARRY APPEL

Occupational Diseases of the Skin. By Louis Tahantz M D, Louis Talipan M D and Samuel M Peck, M D Second edition. Octavo of 964 pages illustrated Philadelphia Lea & Febiger, 1917 Cloth \$12.50

This book is a thoroughly revised and enlarged second edition of Occupational Diseases of the Skin. The 165 extra pages include not only additional text matter but more illustrations and a large bibliography Dr S M Feek has been added also as a co-author Drory chapter has undergone a thorough revision, and two now chapters one on occupational acme and another on the medicolegal aspects of occupational diseases have been bidded. This book can be highly recommended as one of the best on the subject and should be in the library of everyone interested in occupational diseases.

ABRAHAM WALTER

Aging Successfully By George Lawton Octave of 266 pages. New York Columbia University Press 1946 Cloth, \$2.75

We do not think that too many books on this subject have yet been written. As the author gives us to know if we do not already the aging and aged portion of our population is increasing and much provision, physical and for his position sociologic and psychologic must be made

The reviewer's largest criticism of the book is that as in the case of some books on physical medicine, diagnosis symptoms, and case reports take up too much room, while the reader is looking for treatment. The book recommends many useful measures to the aging and also urges the younger to give them more help. We recommend the book to both these andlences.

WALTER D LUDLUM SIL

Vitamins and Hormones Advances in Research and Applications. Edited by Robert S Harris and Kenneth V Thimann. Vol IV Octavo of 400 pages illustrated. New York Academic Press, 1940 Cloth \$6 50

This book is better described by its secondary title Advances in Research and Applications since it commits of an historic review of the advances and a series of monographs of extremely scholarly type on specific problems connected with vitamins and hor mones

The compilation is well made and for a student with advanced training in the field, is an excellent source book. The average busy practitioner will not find this a good source of easy orientation in the field of 'vitamins and hormones' as the title seems to imply

HENRY M FLINBLATT

Office Treatment of the Bye By Elias Solinger M D Octavo of 542 pages illustrated. Chleago Year Book Publishers 1947 Cloth \$7.75 This should be useful to the resident in charge of treatment and emergency rooms in large hospitals as well as to physicians in the treatment of patients in private offices. The work not only deals with minor surgical and external diseases but includes sections on the technic of examination and instrumentation. The material is well arranged, and the illustrations are, for the most part, clear and instructive. Each chapter is followed by a list of references.

JOHN N EVANS

A Guide for the Tuberculous Patient. By G S Erwin, M D American edition revised and edited by Henry C Sweany, M D Duodecimo of 126 pages, New York, Grune & Stratton, 1946 Board, S1 50

A Guide for the Tuberculous Patient is a small book intended for the edification and instruction of the layman. As such books go, it is fairly well contrived and probably serves a useful purpose in more nearly orienting the layman and the patient to the problems and vicissitudes accompanying the routine management of cases of pulmonary tuberculosis. It is not better nor worse than a dozen other such works. One wonders where the need exists for so much duplication of effort in this line.

FOSTER MURRAY

Adolescent Sterility A Study in the Comparative Physiology of the Infecundity of the Adolescent Organism in Mammals and Man By M F Ashley Montagu Octavo of 148 pages Springfield, Ill, Charles C Thomas, 1946 Cloth, \$3 50

Dr Montagu's interesting little book argues convincingly in favor of there being a time interval between the appearance of the first menstruation and the ability to conceive and carry a fetus to term

In the first section the known material with regard to lower animals is given. In the second, a persuasive case is made for the belief that a similar interval exists for human beings. In the third, and briefest section of the work, it is argued much less convincingly that very young women are not physiologically prepared for childbearing and have higher infant mortality and stillbirth rates. This may well be, but the author has not demonstrated that there is necessarily any relationship between this and the existence of a period of adolescent sterility. This somewhat controversial conclusion in no way

detracts from the merits of a well written and provocative monograph which will be of interest to obstetricians, sociologists, and others

MILTON PLOTZ

Treatment of the Patient Past Fifty By Ernst Boas, M D Third edition Octavo of 479 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth, \$5.75

This is a brief practical guide to the diseases of old people. It manages to cover most of the important ailments which the practitioner meets. Some of the very practical therapeutic points covered are night cramps, senile and postmenopausal osteoporosis, Parkinson's disease, gout, and diabetes

ANDREW BABEY

Miracles from Microbes The Road to Streptomycin By Samuel Epstein and Beryl Williams Large duodecimo of 155 pages New Brunswick, Rutgers University Press, 1946 Cloth, \$2.00

The authors have presented in a chronologic fashion the story of the discovery and the development of the antibiotics, including the latest information regarding streptomycin. This book is not only valuable for its historic and factual presentation, but it also reveals how an unrelated science, such as soil bacteriology, has contributed to our medical knowledge. This book should be read by every physician, scientist, and layman

CASPAR G BURN

Constructive Meal-Planning By N Philip Norman, M D Octavo of 72 pages Passaic, New Jersey, Phototone Press, 1946 Cloth, \$2 50

In this small volume the author propounds a theory that the three meals daily should be divided as follows Breakfast—fruits and milk, lunch—starches, dinner—proteins This is the old vegetarian credo The author however permits the addition of meat in the protein meal

The blanket accusation against processed foods is unjustified especially in view of the recent world events. The lives of millions of people were saved from starvation by stock piles of processed foods. The reviewer suggests that the author enlarge upon the subject matter or the lay reader may be led into an unsuspected vegetarian alley.

MORRIS ANT

ANNUAL CONFERENCE OF HEALTH OFFICERS AND PUBLIC HEALTH NURSES

The Annual Conference of Health Officers and Public Health Nurses will be held in Saratoga Springs, July 21 to 23 The plans include five general sessions beginning on the morning of Wednesdav, July 21, and ending at noon on Friday, July 23

The program on Tuesday, July 20, will be devoted to the meeting of the New York State Association of School Physicians and the New York State School Nurse Teachers Association, and to such preliminary meetings of public health personnel as may be desired Headquarters will be at the Grand Union Hotel

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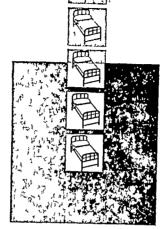
Should your reservation be received after the six hundred rooms set aside for the Society at the Hotel Pennsylvania have been assigned, your reservation will be turned over to one of the neighboring hotels—the Hotel New Yorker, the Governor Clinton Hotel, the Hotel McAlpin, the Hotel Martinique Please indicate your preference on the reservation blank Confirmation of your reservation will come to you direct from the hotel making the accommodation

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If You Are Reading a Paper at the 1948 Annual Meeting

the New York State Journal of Medicine will appreciate your following the suggestions listed below in the preparation of your manuscripts. Since the Annual Meeting papers are submitted to the Journal for publication, your cooperation in heeding these suggestions will save correspondence, avoid the return of scientific papers for revisions, minimize the work of preparation for the printer, and save the high costs of corrections made on the galley proofs

Size of Articles —It is earnestly desired that scientific articles shall not exceed 6 Journal pages at the outside —Longer articles tend to lower reader interest. An average of five or six seems to be the most desirable from this point of view —Calculation can readily be made by multiplying the number of double-spaced typewritten manuscript pages by the fraction two-fifths, e.g., twelve manuscript pages will make five Journal pages

Manuscripts —Papers must be typewritten on one side only of white sheets consecutively numbered, and be double spaced with one-mch margins. They should be prepared with great care so as to be typographically correct. All headings, titles, subtitles, and subheadings should be typed flush with the left-hand margin. This is imperative for rapid and accurate composition by the printers.

Titles—The title should be brief and typed in capital letters. The subtitle can be longer and should be typed in caps and lower case letters. Under the title, or subtitle, if there is one, should appear the name of the author and city in which he lives. Directly under his name should be the hospital or institution with which he is affiliated.

Subheadings —Subheadings should be inserted by the author at appropriate intervals

References—It is the unfaling practice of the New York State Journal of Medicine to use specific "references" rather than "bibliography" There should appear in the text reference numbers, typed above and to the right of the word to which there is a reference A list, consecutively numbered, of these references should follow at the end of the manuscript (Note that spelling in list is same as in text) The arrangement should be as follows and should include all items

 Books—author's surname followed by initials, title of book, edition, location and name of publisher, year of publication, volume, and page number Thus, Osler, W Modern Medicine, 3rd ed, Philadelphia, Lea & Febiger, 1927, vol 5, p 57

b Periodicals—author's surname followed by initials, name of periodical, volume, page, month (day if necessary), year of publication Thus, Leahy, Leon J New York State J Med 40 347 (March 1) 1940

NOTE The JOURNAL does not include titles of articles

Case Reports —Instead of abstracts of hospital histories, authors should write these reports in a narrative style with properly completed sentences All unimportant details should be deleted with such general negative statements as fit the case

Tables —While tables are very useful on lantern slides in the reading of papers, they fail of this purpose to a large extent in the printed page —For that reason it is urged that they be reduced as much as possible to descriptive language

Illustrations —These should be kept to the minimum necessary to make clear the points to be registered by the author. In some instances they are imperative to proper understanding, in others they are merely picturesque. The latter can be excluded to good effect, both as to space and the not inconsiderable cost.

When illustrations are to be used they should accompany manuscripts and each should always be referred to in the text, preferably by number Drawings or graphs should not be larger than 12 × 16 inches, and must be made with jet black India ink on white paper Do not use typewriter for lettering The smallest lettering on 8 × 10 inch copy should be no less than ½ inch high. Cross-section paper (white with black lines) may be used, but should not have more than 4 lines per inch If finer ruled paper is used, the major division lines should be drawn in with black ink, omitting the finer divisions In the case of finely ruled paper, only blue-lined paper can be accepted Lettering and all markings must be large enough to be readable after reduction Mail rolled or flat, never fold Photographs should be very distinct and show clear black and white contrasts They must be on glossy white paper Avoid round and oval photographs Whenever possible "crop" photographs, i.e., marks over the contrasts of photographs.

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With Mayor William O'Dwyer, State Senator Thomas Dommond and other public officials business labor and professional men as honorary sponsors the Federation Employment Service an affiliate of the Federation of Jewish Philanthropies of New York undertook a campaign here during April to secure employment for older workers, those over 45 years of age and to educate the public as to

the fitness of older people for employment Under the slogan, Experience Loyalty Skill— Under the slogan, "Experience loyalty Shin Come With Age the campaign was conducted as a special project of Federation Employment Service, New York City a free and nonsectarian agency, simultaneously with its normal operation as a job placement and vocational guidance bureau

Citing a survey conducted by the New York State Legislative Committee on Problems of the Aging, Mr Arnold Askin co-chairman of the cam paign said that industry rates employes past 45 years of age as more loyal, absent less frequently, and as productive as their junior workers. survey which embraces the experiences of 1 000 amployers also revealed that older persons were more experienced more conscientious and less distracted than younger people.

A general review of studies made in connection with the job problems of older persons Mr Askin

said, reveals three things

1 Because of family responsibilities middleaged and older workers are less subject to turnover 2 Employers prefer older workers in jobs calling for experience and judgment and on jobs where quality is more important than speed.

3. Older workers suffer fewer industrial accidents according to findings of the U.S Bureau of Labor Statistics

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"Constipation is the rule. The pressure of the gravid uterus mechanically interferes with the function of the small intestine and colon per se and also renders the act of defecation less efficient by its effect on the diaphragm, abdominal muscles and levator ani "

> -Bockus, H L Gastro-Enterology Philadelphia W B Saunders Company, 1946 vol 3 p 999

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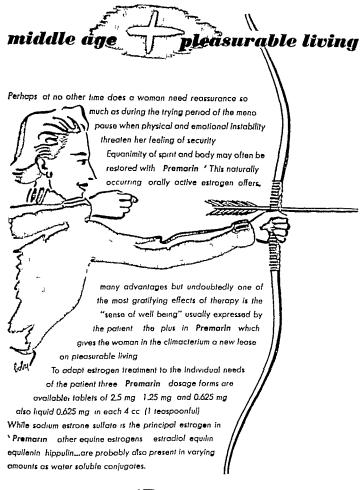
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*Solubase Brand 1. New England J Med. 213 279 1935

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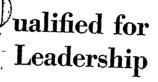


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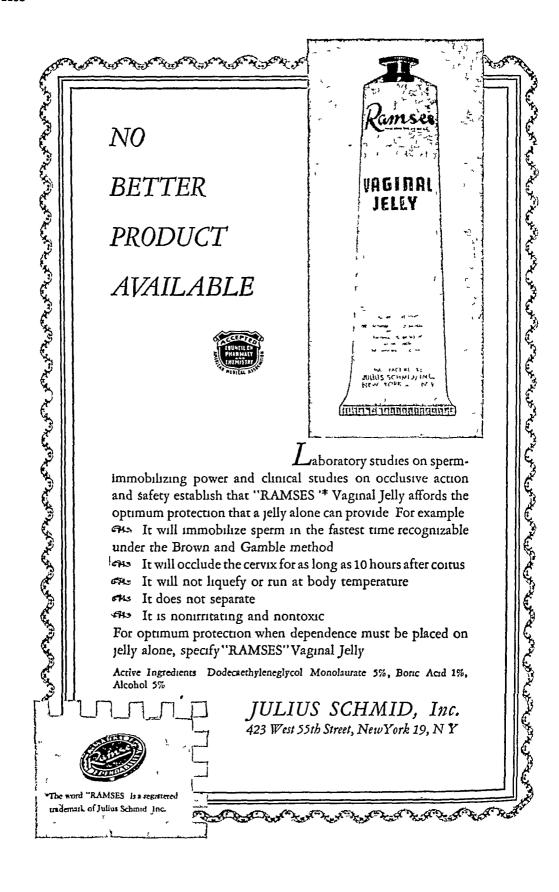
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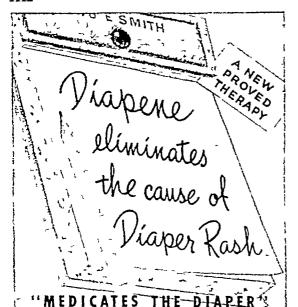
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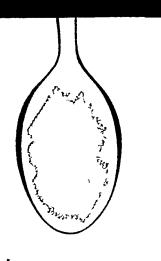
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*Healy J C.: Hypochromic Anemia: Treatment with Molvbdenum-Iron Complex, J Lancet 66.218 (July) 1946.

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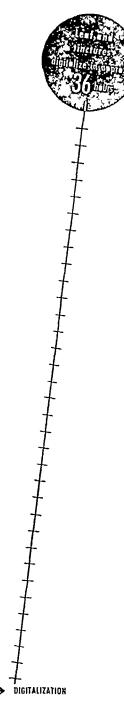
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1, Carroll, Cl., and Allen, N H. J Ural, 55: 674 (1946)

2. Klewin, T. J., and Bridges, J. P.; Am. J. Surg. 52: 477 (1941).

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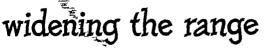


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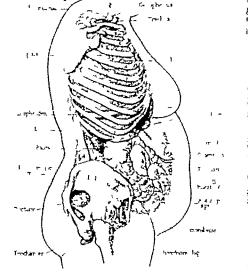
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The Transment of Experiencion, editorial, J. A. M. A. 132:576 (Nov. 1) 1947

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Denovan, M. A. New York Stat. J. Med. 45 1754 (Aug. 15) 1945.

well talerated locally, a duretic of choice

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 Modil, W., Ook, H. and Clarke D. A. J. Phara, & Exper. Thomps. 84-281 (July) 1945.
- "The authors favor the administration of mercury intramuscularly rather than intravenously and for this purpose employ preparations such as MERCUHYDRIN"

Thorn, G. W. and Tyler F. H. Med. Clin, North America (Sept.) 1917 p. 1931,

 The results of our experiments suggest that the greatest cardiac toleration for a mercurial diuretic occurs with MERCUHYDRIN"

Chapets D W and Shaff r C. F : Arch. Internal Med. 79 419 1947

 We have limited the use of chemical diuretics almost entirely to MERCUHYDRIN"

Weiser F A.: Grace Hospital Bulletin, Detroit (J m.) 1947 p. 23,



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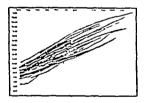
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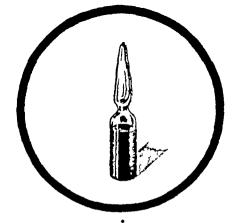
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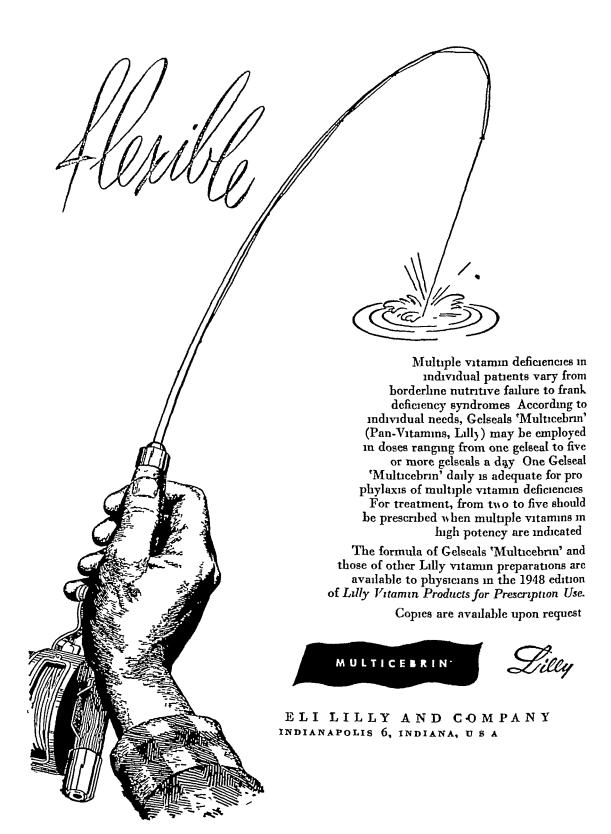
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Editorials

Population Increases

The Statistical Bulletin discloses the fact that, in the United States in 1947, natural population increase rose to a "new high mark, one which may never again be equaled Thanks to an extraordinarily large number of births and to a low death rate, the natural increase—the excess of births over deaths—exceeded 2,400,000 in 1947". This figure, the Bulletin states, is about as large as the average number of births a year in the decade between 1930 and 1940.

The fact of this increase, startling enough in itself, seems dwarfed by its implications. The crude rate of natural increase in 1947 was 1 7 per cent, apparently not encountered previously during the last half century or more. A little thought about the significance of this population increase, its rate, and its impact on the future development of the country opens amazing vistas. These should be considered against the world background since the beginnings of recorded European history in the sixth century.

Werner Sombart, the noted economist, stressed the fact some time ago, as pointed out by Ortega v Gasset 2 that from 1200 to 1800 A D the population of the Western World remained almost constant Europe stood during that time at fewer than 180,000,000 inhabitants. However, from 1800 to 1914 "the population of Europe rose from 180 to 460 millions"

In considering our population increase, it would be well not to overlook this amazing demonstration of the enormous fertility of Western Europe Emigration to this continent since 1800 of the overflow of Europe undoubtedly has provided a large part of the stock from which the fertility of our recent natural population increase has been derived in the United States.

Will the next century witness a repetition in Europe of the startling population growth of 1800 to 1914? Or is the present high natural increase in the United States the commencement of a cycle of increase in this country by the descendants of those Europeans, transplanted to the favorable environment of the western hemisphere, who produced so prolifically in the last century? May we perhaps anticipate simultaneous cycles of increase, one in Europe and one in the western hemisphere, which will people the earth to an extent before unknown? And what of the Assate peoples and those of

¹ Met Life Ins. Co. Doc., 1947 p. 3.
2 Revolt of the Massex, W W Norton and Co. Inc., New York, 1932.

Eastern Europe? Is a cycle of increase due also in those countries? It is not impossible

The prospect unfolded here is of the greatest significance to physicians. The population pressures which could be created by a coincidence of increases in different parts of the world would place a staggering burden upon the medical profession. Under modern concepts of medical student training and postgraduate instruction the time necessary to train qualified practitioners, the facilities of plant and structure which would be required, and the cost of providing competent, well-implemented professional medical service, to say nothing of the ancillary services, deserves serious thought. The

World Medical Association, it would appear, has not been started any too soon. As to the status of the World Health Organization, a United Nations sibling, its constitution has been ratified at the date of this writing by only 17 of the necessary 26 members of the U N ³

Will the rapidity of population increase wait upon the crawling pace of present organizational development? These oncoming masses of humanity with their inevitable demands for food, shelter, medical service, sanitation, warmth, light, and education will strain even the resources of an atomic age

Is Medical Care Expensive?

Dr Frank G Dickinson, Ph D, economist and statistician, director of the Bureau of Medical Economic Research of the American Medical Association, releases facts on costs of medical care which deserve careful consideration ¹

Dr Dickinson spoke before the afternoon session of the 15th anniversary meeting of the American Association of University Teachers of Insurance at the Drake Hotel, Chicago, Illinois, recently

In his prepared address, entitled "Cost, Supply and Demand Problems of Medical Care." Dr Dickinson observed that "the present demand for medical care is very different from what it was a decade ago and probably very unlike what it will be a decade hence The peak birth rate, high consumer incomes, the increasing number and percentage of older people, not to mention the wonder drugs and other revolutionary changes in medical treatment, have combined to confront even the most courageous student of demand functions with a rather formidable array of puzzling variables In addition, there are many unmet medical care needs "

Despite increasing demands for medical care and rising costs of specific treatments, Dr Dickinson pointed out that since 1940 the proportion of national income spent for medical services has actually declined Costs of medical care tend to move contracyclically,

he explained In a depression such costs comprise a larger share of total consumer expenditures and national income than they do in prosperous times in 1932 and 1933 medical care took 44 per cent of total consumer expenditures, as opposed to 39 per cent in 1946

The declining percentages of income and total consumer expenditures spent on medical care are paralleled by increasing proportions spent on alcoholic beverages, recreation, personal care, and jewelry, he said. These items in the budget of the American people were selected by Dr Dickinson not for moral reasons but for comparability in size.

The physicians' share in the medical care dollar has declined from 32 cents in 1929, to 31 cents in the 1935–1939 period, to 27 cents in 1945, the dentists' share has declined from 16 cents to 13 cents, he continued. On the other hand, the hospitals' share of the medical care dollar rose from 13 cents to 17 cents and fell to 16 cents in 1945. Drugs rose from 20 cents to 21 cents and finally to 23 cents, undoubtedly reflecting the large expenditures for the so-called wonder drugs.

One thing cannot be reduced to statistics—the superior kind of medical care that the American people are now getting in contrast to the 1929 variety—The contrast is comparable to a 1946 car and a 1929 car—The Bureau of Medical Economic Research has estimated for 1947 a life expectancy of 67 years—Modern medical care costs money, for it costs money to postpone death

^{*} J A.M.A. 136 335 (Jan. 31) 1948

¹ A.M.A News (Dec. 26) 1947

Those lay and professional people who direct the expenditures of Americans for medical care may be expected to derive no more than a fleeting moment of satisfaction from these conclusions regarding the cost of medical care. The domand for improved medical care is well nigh insatiable and those who try to provide it are subject to easy criticism. They know that the quest for health, improved medical care and longer life is never-ending They have an unlimited opportunity to improve medical care and at the same time are exposed to the challenge of attaining one goal only to find that the goal has been moved up. So long as pain comes too often and death comes too soon to human beings, truly adequate medical care will remain beyond our reach forever

We anticipate a flood of arguments on this subject whon debate commences in various legislatures and in the Congress. For those interested in informing themselves in more detail we bring to your attention publication No 60 of the Bureau of Medical Economic Research, A.M.A., "Is Medical Care Expensive?"by Frank G Dickinson, Ph D of which the above speech is a brief condensation

Serious study of the cost of physicians' services, as cited in the above source, shows that "the slowest moving item in this series (of consumer expenditures 1935 to 1947), that is, the one which increased most slowly in every single year, was the expenditure for physicians' services, unless the item for 1948, when it is published months hence, is an exception to this statement ' 2

In the year 1929 money paid to physicians was 23 cents of the dollar spent for medical care (on physicians, for hospital, drugs, dentists and other, not further classified. In 1935 to 1939 it was 31 cents, items) and in 1945, 27 cents. Considered in this light, the actual cost of physicians' services related to the whole dollar spent for medical care seems not to be excessive and is surely not following the trend of generally rising costs of everything else. This fact would seem to be important to convey to the pul-If medical care is considered as a whole, the average citizen is likely to think that physicians' fees constitute a larger part of that whole than they can actually be demonstrated to be in such studies as are here anoted

The average citizen is quite likely to particularise For that reason he would be likely to listen acutely to anyone who might claim that he was paying too much for physicians' services. He might conceivably feel better about the whole matter if he knew that, while not cheap, the services of physicians to the barrel-clad taxpayer were moderate and, of recent years, trending somewhat downward in spite of the very apparent rise in cost of nearly all other services and of nearly all commodities. It is up to the medical profession to inform him Studies such as are being done by the Bureau of Medical Economic Research of the A.M.A. seem to us to be of the utmost value at this time particularly A few unassailable facts are superior to much propaganda

Praise Indeed

When the New York Daily Mirror writes editorials for us that is news. Witness now For many years Mr something else again W R. Hearst has snarled at the medical profession over the bone of animal experimentation in his various publications.

In an editorial ' Progress of Health,"1 we

read.

of better than 65 years. The public is forewarned about these (heart disease and cancer) as never before, the amount of combative research is unprecedented So much is known about the arrest and prevention of tuberculosis today that some public health prophets predict "the great white plague" eventually will be wiped out. Smallpox, once a common death dealer, has been eliminated to the extent that doctors are unfamil

The health of the country goes right on improv

There is at birth an average life expectancy

^{*} Dickinson, F. G. La Medical Care Expensive? A.M.A. Buresu of Medical Economic Research p. 8 (194)

iar with its symptoms (Except when cases recently were recognized and New York City subjected to mass vaccination)

Most of our strides in medicine and research have been made under the free practice of the profession, free pursuit of research, with funds provided by private fortunes, great charitable foundations and contributions of the public. There is no indication that our medical progress is faltering in any way, but the bureaucrats in Washington, recognizing a good thing when they see it, think they could do a better job. Mr. Truman's master plan to socialize or nationalize the medical profession at a cost of \$5,000,000 a year—taxes to come from the people—represents the latest plan to "take over," thus aping the

As it is working out in Britain, the doctor is subject to 350 pages of rules and regulations (remember the O P A?) and, through its licensing powers, the government can, in effect, squeeze him out of his current practice and reassign him

cradle-to-grave "security" scheme being tried out

ın Britain

Of course, sordid politics are never supposed to interfere in these high minded schemes, but somehow they always do—particularly when politicians are intrusted with administering billions of dollars

Sure—our free system has defects But, in medicine as in other endeavors, it is the main-spring of a going concern. It is successful. It progresses. It is a living fact, in contravention of the hopeful visions and unfulfillable promises of the socialist planners.

As we finish these quotations we feel as if our perspiring brow had been fanned by a fresh breeze of spring. They contain, to be sure, nothing but what this and every other medical journal in the country have been saying for a long time. But what this and other medical journals say on the subject medical care, apparently, has but little direct influence on the public. We submit that at the present time the medical profession should have more weight and influence, not less

We would not, of course, have doctors invade the sickroom with a stethoscope in one hand and a copy of this editorial in the other, but we are of the opinion that doctors should be more lively than they are in everyday presentation of the case of their profession. Undoubtedly, we shall have to wait for a long time for such a desired change to come about. But in the meantime we are much refreshed by the Daily Mirror coming in on the side of mediane.

If Mr Hearst can, for a moment, submerge his horror over the use of dogs for the benefit of humans in his admiration for the medical profession in its achievements for world health, who knows what may be the next miracle? The Russians backing up the Marshall Plan? Who knows?

Current Editorial Comment

Reduced Life Expectancy in High Altitudes

Living in a high altitude reduces the life expectancy even for persons who are acclimated, according to a report from the Bolivian correspondent of the *Journal of the American Medical Association*, writing in the February 7 issue

A study made in that country compares birth rates, mortality rates, and life expectancy in three sections of Bolivia first, the moderately cool districts where most inhabitants live constantly at average altitudes exceeding 10,000 feet, second, the subtropical districts with an average altitude between 3,000 and 10,000 feet, and, third, the tropical districts situated at an average altitude of less than 3,000 feet

Surprisingly, birth rates were higher in the

first and second zones, above 3,000 feet They were best in the second zone and were followed by those of the highlands Mortality rates were almost identical in the first and second zones, but were comparatively higher than in the lowlands (15 7 per cent as against 9 3 per cent)

"The effect of altitude on infant mortality is noteworthy," the article observes "Although in the lowlands with its tropical climate and high incidence of malaria the annual mortality rate stayed at 93 3 per thousand, the corresponding figure for the highlands was 142 2 per thousand. Thus a baby born near sea level had 50 per cent more chance to survive his first year of life than did his companion at 10,000 feet. The relative frequency of whooping cough and congenital weakness accounts for some of the additional deaths in

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zone 1, but does not explain completely the difference as against zone 3, nor are there any better hospital and medical facilities in the lower sections of the country than in the ligher ones

"Striking differences to altitude became evident in the death rate of the age group from one to five years. While only one eighth of all the deaths belonged to that group in zone 3 in zone 1 more than one quarter of the deaths had been in that age group. Again no one specific disease could be blamed for this relative excess in zone 1, even though diseases of the respiratory tract were somewhat more frequent in that section.

"Less striking were the differences in the age group from five to 14 years but even there the child of the lower altitudes had a better chance of survival Figures for the age groups from 25 to 64 show a lower death rate in zone 1, figures for the ages above 65 are fairly mixed for all the sections The average ages of death were as follows zone 1 about 31 years, zone 2 about 34 years, and zone 3, about 37 years'

The Meanest Man in the Profession? Nothing but the sternest sort of conscience would persuade us to publish such a comment as the above on a colleague We quote from the New York. Times of October 27, 1947

Daniel A. Wedge, one of the oldest Civil War veterans in this country died today on his 100th birthday in the home of his daughter Miss Mable Wedge in nearby Aurora Illinois He had been confined to his bed by a broken hip for twelve years but had been in fairly good health until recently He also was the commander and last surviving member of Aurora Post 20 G.A.R. He never missed a Memorial Day Parade and rode in them in an ambulance after he became an invalid until this year when his doctor forbade it His only survivor is his daughter who gave up a teaching position to care for her father when he suffered the broken hip

The only excuse that we can think of for the doctor responsible for this tragedy is that he must be president of the local Geriatric Society, shooting for a record for his one hundred and six year-old patient if that was his excuse, he has forfeited it because in the same column of the New

York Times there is recorded the death of Colonel Charles Louis Hooker.

last surviving member of the Alonzo Palmer G.A.R. Post of Superior Wisconsin, who died liere last night at the home of his son with whom he had lived for the last fifteen years He was 107 years old

To break one's hip at the age of ninety is a calamity, to say the least To have a daughter willing to give up her teaching position to care for her father for twelve years after is either a triumph of filial af fection or another tragedy. It depends on the way you look at it We wonder if father and daughter kept a calendar on the wall and scratched off the days that brought them nearer to each Memorial Day We know nothing of Aurora, Illinois. but we are sure that the pair-not being Charles Dickens, we do not say the devoted pair-looked eagerly forward to each anniversary, that the greatest consolation for their mutual affliction was the great day when they would be for a brief period the most prominent figures in their com munity

The daughter of a man 106 years old must be fairly well along herself. For her father she may well have sacrificed her chances of marriage and children of her own. As her decades rolled by she must have had many a bitter moment, thinking of the long-lived children that she might have borne. When her father broke his hip and was condemned to a future of inactivity, of constant pain, of undoubtedly increasing querulousness and irritability, what had she to look forward to but that one day out of the year?

As for lum, he must have had his qualms of conscience, too On every occasion that his spinster daughter ministered to him—and the ministrations necessary to old age are not pleasant either to the donor or the recipient—he must have reflected how much better it would have been for both of them had he been shot by some Southern marksman, perhaps as he stood sentinel before the tent of General Grant

We think of this aging father and daughter, as Memorial Day approaches bringing out the relics of far bygone days, brushing the campaign hat darning moth holes in the blue tunic, oiling up the sabre so that it slid smoothly from its sheath, scanning the weather reports—wondering wondering would they be vouchsafed one

more anniversary on which they might be the cynosure of every eye in Aurora, Illinois?

And then the doctor tells him that he can't take part in the parade Aside from our suggestion in regard to the doctor's interest in genatrics, we will not presume to explain or excuse his decision. He certainly took upon his shoulders a burden that we should be content to leave to almighty God. We recall Macaulay's lines—

And how can man die better, Than facing fearful odds, For the ashes of his fathers And the temples of his Gods?

Perhaps the appearance of a father and daughter in a Memorial Day parade would not quite merit Macaulay's quatrain, but it comes as close to deserving it as anything of which we can think in these modern times

Who was the doctor? What is his conception of his place in society, of his duty toward his patients? Who is he to deny the old man the pleasure of passing the reviewing stand, rising to his feet, steadying his twelve-year-old broken hip perhaps with hand upon his daughter's shoulder, saluting the colors, and, if God is good, falling dead at the long anticipated climax of his life? Who is any man to presume to prolong life at the expense of the sacrifice of every bit of its romance, bite, and color?

Vocational Nurses The New England Journal of Medicine¹ comments editorially, under this title, upon the trivial and often menial tasks required of trained nurses by custom and perhaps by thoughtless habit Says the Journal

An analysis of the type of nursing service needed for the modern patient revealed that more than 90 per cent of the calls made could be taken care of by a maid, or indeed, by anyone who happened to be within earshot of the call. Of them all, more than half were to bring or remove a bedpan or urinal. This is, of course, bedside nursing, not operating room or laboratory service, not diet kitchen or x-ray service—in fact, none of the technically specialized activities in which the modern nurse has become so useful. Bedside nursing itself is not so skilled an occupation as we may have

thought it to be The "nurse" has forsaken the bedside for the laboratory, she has become a technician. It might be well if both she and some of the doctors who have likewise forsaken the bedsides relinquished their titles, leaving the influence and prerogatives that are associated with the words "doctor" and "nurse" to those who faithfully continue to serve the sick

A recent survey by the American College of Surgeons indicated that 82 per cent of more than a thousand hospitals were already utilizing adjunct nursing personnel, whereas 60 per cent favored the establishment of training facilities for nurses' aides within their own walls. The time when nursing services within a hospital could be provided by merely opening a school appears to have gone. Gone too are the emotional stimuli that brought competent men and women to the hospital bedsides of the nation during wartime. From now on it seems to be a matter of supply and demand—the supply being admittedly short, and the demand inflated by easy money and Blue Cross contracts

The practical nurse and a more realistic approach to what is required of a registered nurse may yet help to solve some of the problems of the nursing shortage

Dr Louis H World Medical Group Bauer, president of the State Medical Society, has been appointed Secretary-General of the World Medical Association, an honor of which we of the State Medical Society may well be proud Dr Bauer had served as the secretary of the United States Committee formed at Paris last fall and is thoroughly familiar with the world organization which is now launched to cooperate in attacking the problem of the many international problems which affect medicine at the present time It may be hoped likewise that the movement will aid in the establishment of a much desired peaceful state in this world of ours As Dr Morris Fishbein remarked recently, "Faced with the threat of an enormous increase of disease because of the shortages of food, clothing, and shelter throughout the world, doctors must cooperate on an international scale to bring all the benefits of medical care and public health facilities to mankind " A worthy purpose indeed!

¹ New England J Med 238 31 (Jan. 29) 1948

Scientific Articles

RECENT ADVANCES IN COMMUNICABLE DISEASE CONTROL

HOLLIS S INGRAHAM, M.D., Albany, New York

(From the Direction of Communicable Diseases New York State Department of Health)

R ECENT additions to knowledge of the control of communicable disease have been so great that it is necessary to place very definite restrictions on content in a brief review of the subject. The following discussion is therefore largely confined to those procedures which within the past seven years have found general application to certain of the acute communicable diseases most common in New York State

Whooping Cough—Whooping cough is well worthy of first consideration. In recent years, this very common disease has become one of the leading causes of death during the very early years of life. It is necessary to bear in mind that over 50 per cent of all deaths from whooping cough occur during the first six months of life and that most infants are fully susceptible from the very day of birth. The development of effective methods of active immunisation against whooping cough is undoubtedly the greatest advance in the control of this disease.

It is to be admitted that an effective antigen for protection against whooping cough was available well in advance of seven years ago However it is only within this period of time that there has been general acceptance of the practica bility and effectiveness of the measure ¹ Of great significance is the demonstration by Sako and others that the very young infant can develop protective antibodies in response to the injection of pertuasis antigens ² It now appears that in fants as young as one month of age may be satisfactorily and safely immunized. The application of this fact is obvious in view of the concentration of deaths from whooping cough during the early months of life.

Immune serum prepared from rabbits as well as hyperimmune serum prepared from humans has now become available. Both these agents appear to be highly effective for temporary passive protection in exposed infants and are of value in treatment of children already affected by the disease.⁵

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There are three other developments in the field of whooping cough which are worthy of mention It has been shown that immunization of pregnant women during the latter half of pregnancy will result in a very considerably elevation of antibodies in the blood of the newborn infant. The extent to which this procedure is practicable or effective has yet to be shown by a satisfactory field trial Two different skin susceptibility tests have been described *7 The application of these tests appears, however, to have theoretical rather than practical advantage from a public health stand point. Some clinics have reported that in certain cases of whooping cough, streptomyon is an efficacious method of treatment. It appears, however, that this antibiotic is not uniformly effective.

Recent advances have, therefore, made the al most absolute control of whooping cough deaths an entirely practical procedure. It is recommended that all infants should be actively immunized beginning not later than three months of age. Unimmunized infants known to have been exposed to the disease should be given the benefit of either immune rabbit serum or hyperimmune human serum. Young children, who are severely ill with this disease, should be treated by means of serum and possibly streptomycin.

Diphtheria - During these last seven years, the world has had a visitation by diphtheria such as has not been known since the pandemic of the 1880's. The United States Canada, and England have essentially been spared However, in upstate New York, there was an increase from 56 cases and 3 deaths in 1944 to 342 cases and 29 deaths in 1946. From this recent experience. certain old lessons have been relearned. It was once again demonstrated that all cases of diph theria should be treated immediately on clinical diagnosis and that only in this way can a considerable number of fatalities be avoided value of antitoxin and the overwhelming necessity for its early administration have been illustrated again and again. None of the newer drugs can in any way be accepted as substitutes for antitoxin although penicillin may have some

adjuvant value The necessity of bed rest for several weeks following an attack of diphtheria has also been re-emphasized by the numerous fatalities from cardiac failure following early resumption of activity

The most important fact which has emerged from the pandemic has been the reconfirmation that diphtheria can only be controlled by means of active immunization of the majority of the children of the community Epidemiologic reports from every country have testified to the value of adequate immunization against diph-These years have, however, added definitely to knowledge as to the limitations, particularly in time, of artificial immunization One of the great lessons of recent years has been that effective resistance to many communicable diseases can only be maintained in the presence of exposure to the causative agent or its equivalent Better in diphtheria than in any other fever has the value of booster immunization been demonstrated

Studies within the last seven years have proved conclusively the superiority of alum-precipitated toxoid as an antigen to fluid toxoid ⁹ Material recently published on the effectiveness and relatively few reactions from protamine-precipitated diphtheria toxoid is definitely worthy of note ¹⁰ There is also evidence to indicate that toxoids prepared from highly purified toxin may prove to be almost free from reactions ¹¹

It is believed, therefore, that diphtheria can be practically eliminated if every child born in New York State is immunized with two doses of precipitated toxoid beginning at six months of age, followed by a booster dose before the time of school entry and by further stimulation at any time when the disease may appear in the com-It is possible that it may eventually prove necessary to continue the periodic administration of booster doses into adult life This possibility is suggested by the very high proportion of adults who were attacked by diphtheria in two recent epidemics 12 13 There are occasions when familial contacts to cases of diphtheria should be given prophylactic antitoxin British workers have proved that under such circumstances it is permissible to initiate active immunization with alum-precipitated toxoid simultaneously with serum administration 14

Pneumonia—The advent of penicilin added immeasurably to the effectiveness of therapy against pneumonia caused by pneumococci, streptococci, and staphylococci, and this drug has been a very considerable factor in the continuing decline of pneumonia mortality ¹⁵ Streptomycin apparently gives considerable promise as a therapeutic measure in the treatment of certain cases of pneumonia caused by the Friedlander bacillus

The recent period has seen very intensive study of atypical pneumonia and its relationship to the psittacosis group and Q fever has been more clearly defined. Human volunteer tests have shown that primary atypical pneumonia is caused by a filterable agent ¹⁶. Two nonspecific tests, the cold agglutinia and agglutination of streptococcus MG, have proved of limited value in diagnosis ¹⁷.

There appears to be progress in the development of a preventive vaccine against pneumococcus pneumonia, but the limitations and practical value of any such vaccine will require much additional study ¹⁸

Streptococcal Infections — The respiratory streptococcal infections, like the poor, are always with us Although this group of sicknesses has been studied intensively in the war years and knowledge of their fundamental nature is far greater than it was in the recent past, practical methods of prevention still largely elude our grasp Nevertheless, there is progress to report The typing of the various members of the group A streptococci has become an extremely valuable epidemiologic tool The demonstration by Hamburger of the importance of the nasal carrier as compared with the pharyngeal carrier should also prove of considerable practical importance ¹⁹

Studies of epidemics of streptococcal infection in military installations have given further evidence as to the closeness of the association between illness from hemolytic streptococci and a subsequent initiation or reactivation of rheumatic fever ^{20 21} The demonstration of the value of sulfonamide prophylaxis of the streptococcal infections under certain conditions and of the ease with which sulfa resistant streptococci may emerge was a striking scientific contribution but, unfortunately, does not afford great practical application for us at the moment, except among rheumatic fever patients ²²

The status of immunization against the streptococcal infections remains essentially unchanged Under present day circumstances, it is doubtful that active immunization against hemolytic streptococcal infection is a practical procedure

The immediate mortality from streptococcal pharyngitis, both with and without rash, has been falling steadily for half a century. The trend was first accelerated by the introduction of antistreptococcal serum, later by sulfonamides and most recently by penicillin. However, it must never be forgotten that we have witnessed a natural phenomenon of declining virulence, and there are historic reasons for believing that the virulence of the hemolytic streptococci has varied in great cycles heretofore. The severity of sicknesses produced by these organisms has declined in previous centuries to a very low point and then, as inexplicably, has risen, producing

devastatingly high fatality rates. Streptococcal infections are probably as frequent today as they were fifty years ago, and although therapeutle procedures are now relatively efficient and infinitely superior to what they were not long ago, methods of prevention remain far in the van, and it cannot be considered that the streptococci are at present under man's control

Typhoid Fever -- Typhoid fever is declining in frequency in New York State from year to year, and it is one of the few diseases whose ultimate practical obliteration may reasonably be expected without the aid of further intermication of control effort or additional increments of knowledge The period under consideration has seen the practical application of two interesting and valuable laboratory tools, phage typing of typhoid bacilli, and the Vi agglutination test for detecting typhoid carmers.23-26 The use of these procedures has been of definite assistance in the epidemiologic investigation of cases.26 status of prevention and treatment of typhoid fever has been essentially unchanged. There is also little new to offer in the treatment of carners. Recent literature has suggested that massive doses of penicillin given in conjunction with sulfonamides may be of value in clearing the chronic carner state It is hoped to test this procedure further in the immediate future "

Smallpex —We in this State have recently witnessed the reintroduction of virulent smallpox after the disense had been completely absent in all forms for a seven year period. A total of only a dozen cases resulted, illustrating again the effectiveness of vaccination in preventing the spread of the disease.

As in the case of diphtheria, the recent outbreak tended largely to demonstrate anew the veracity of old knowledge The extensive vaccination campaign did bring out one fact which has never been properly appreciated in the past It is believed that over 7,000 000 people were vaccinated in the State during April and May A number of these individuals died during the course of the next month, but it is improbable that any of them died directly as a result of vaccination It appears that there were no fatal cases of postvaccinal encephalitis or tetanus However, it is known that five eccematous chil dren, who were not themselves vaccinated but who were intimately associated with vaccinated persons, contracted a widely disseminated vaccinia from this contact and died. Thus, it is necessary not only to be wary of vaccinating persons actually suffering from eczema and similar skin diseases but to warn families of the danger of permitting recently vaccinated persons coming in contact with ecsematous children

One of the most interesting increments to small

pox lore was the recent revelation by English workers that the dry crusts from variolous lesions may contain a living virus for over a year when kept at room temperature. This fact has long been suspected, and, indeed, it would appear to have been considered to be common knowledge that the clothes of smallpox victims were infective for some weeks after the deaths of the original owners. It is said that some of the early settlers waged successful biologic warfare against the Indians by giving them blankets and clothes recently worn by smallpox patients.

The investigators in New York City are strongly of the opinion that several of the recent cases of smallpor were infected by a true airborne spread which reached out as much as four floors away to seize new victims. This again is a confirmation of what was at one time considered to

be common knowledge

All recent information confirms the long known fact that primary vaccination within the first year of life is vastly safer than at any subsequent time and is far less disturbing than to older children Recommendations as to immunisation remain unchanged all infants should be vaccinated within the first year of life, the earlier the better, with revacuination every five to seven years thereafter

Measles —The control of measles has not been greatly advanced in the last septennium Efforts have been made to immunize against the disease by means of an egg-grown virus, but the results to date have not been entirely successful. ™ The use of gamma globulin as a temporary prophylactic is the only advance in this disease which can be reported. ™ This proved highly successful but scarcely more so than the previous use of serum or placental globulin Penicillin is, of course, of great value in the treatment of certain complications

Meninguis.—The prophylaxis of meningooccal infection by means of sulfonamides proved to be brilliantly successful in military installations.²² Since the disease tends to occur sporadi cally under civilian conditions, the applicability of the method is exfremely limited at the present time. The therapy of the meningococcal infections, although highly satisfactory by means of the sulfonamides, has been further augmented by the addition of penicillin

There has been remarkable progress in the treatment of meningitis caused by type B in fluenza bacilli. The combined use of rabbit serum and sulfadianne proved to be effective. More recently, streptomycin has been found to be of great therapoutic value. The proper exhibition of these three drugs is strikingly successful when treatment is begun sufficiently early. Penicillin is also of value in some cases. Since influenzal

meningitis is unquestionably the commonest type of meningitis in children under five years of age, it is extremely important that every case, particularly in this age group, be accurately diagnosed as early as possible. A culture of the spinal fluid should be requested in every instance from the laboratory, since the influenza bacillus, being polymorphous, can easily be mistaken for the meningococcus on smear, and there is a strong suspicion that this very error costs the lives of a number of children every year

Influenza and Common Cold —Knowledge of the common cold and of influenza has been markedly enhanced by wartime studies. The Army Commission on Respiratory Diseases has published evidence which indicates that non-influenzal, respiratory infections of the common cold type may be caused by at least two different filterable agents ³⁵ Recent verbal communications indicate a common cold virus has been grown in eggs by both American and English workers

In the study of the epidemiology of influenza, the development of the red cell agglutination inhibition test and the complement fixation test have been of immense benefit, and these tests will continue to aid in understanding of the disease ³⁶ ³⁷

The development of an egg vaccine against influenza must be counted among the very significant advances, even though the practical value of immunization against influenza has yet to be fully delineated ³⁸ It does not appear to be advisable at this time to urge universal immunization against influenza by means of the present day vaccines, largely because of limitations imposed by lack of protection against all strains of virus, as well as by the duration of immunity and severity of reaction

Tetanus—The value of tetanus to\oid was convincingly demonstrated during the recent war ³⁹ Tetanus to\oid appears to be one of our most effective antigens with a duration of protective effect not yet fully measured ⁴⁰ Its exact place in routine immunizations in infancy is still subject to some discussion, merely because of the relatively small risk of contracting tetanus that any one individual runs under the ordinary conditions of civilian life. There can be no doubt that the routine administration of tetanus to\oid in combination with diphtheria to\oid is a worthwhile procedure.

Rabies —Although there have been but six human rabies deaths in New York State in the last seven years, the disease has been more prevalent in domestic and wild animals than in any previously recorded period. There is now convincing evidence that the active immunization of a substantial majority of the dogs in a geographic

unit, the size of a county or larger, can be very effective in controlling canine rabies 42

The Habel test for potency of rabies vaccine has stimulated the production of much more highly protective vaccines than were previously available ⁴¹

Typhus—It is difficult to leave a discussion of this type without making some mention of the typhus fevers, since certain of the typhus fevers do occur in New York State and because of the truly remarkable discoveries in this group Rocky Mountain spotted fever is confined to Long Island, where approximately a dozen cases a year are reported—Brill's disease occurs in New York City and rarely in other parts of the State

During the recent world war, there was demonstrated conclusively the protective value of the Cox type of typhus vaccine against epidemic typhus 48 The Naples epidemic also gave dramatic proof of the value of DDT powder in limiting the spread of this disease " The standardization of complement fixation tests to differentiate the various members of the typhus group has been of the highest theoretical and practical interest 45 The Weil-Felix agglutination test, using the proteus OX-19 and OX-K organisms, has done yeoman service these many years and is yet a valuable tool in diagnosis However, one cannot with any certainty distinguish between Rocky Mountain spotted fever and the other members of the group by means of the Weil-Felix test, and one can make no differentiation whatsoever between endemic and In addition, wartime studies epidemic typhus brought out that OX-K antibodies in high titer are developed practically as frequently in relapsing fever as in scrub typhus 46 Nowadays, however, by complement fixation, Rocky Mountain spotted fever can be clearly differentiated The serologic distinction can also be made between epidemic or louseborne typhus and murine or fleaborne typhus, except among persons previously immunized against typhus The complement fixation test has given further proof, if any were needed, to Zinsser's demonstration that Brill's disease, as it occurs in New York City, very largely represents reactivations of the fever occurring in immigrants from epidemic typhus areas 47

The development of para-aminobenzoic acid as a therapeutic agent for epidemic typhus was one of the very considerable accomplishments of the last war ⁴⁸ There is good evidence that this agent is also effective against scrub typhus and Rocky Mountain spotted fever ⁴⁹ ⁵⁰ Para-aminobenzoic acid must be given in heavy dosage to be effective

Control of Airborne Infections —In the case of ultraviolet irradiation, wartime studies demonstrated

strated an effect on the control of respirators diseases in military barracks, but recent reports on use in schools only partially confirm the original reports by the Wells ^{51 52}. The ultimate value of glycol vapors and of dust is also still un certain despite some very remarkable studies by army groups and others ^{52 54}. Suffice it to say that these methods require further investigation and evaluation before they can be recommended for routine installation in schools and other public gathering places.

Anthrax and Tularemia.—For these two discusses which occur in New York State, there have been marked thempeutic advances. Penucillin is effective in anthrax, and streptomycin appears to be specifically curative for tularemia.

New Problems —It should be mentioned that while control methods have been doveloped for many of the older diseases, new problems have also been brought to light within the recent past yone of these diseases are already in the process of solution, and others await further developments for their control. Among these, we include epidemic kerntoconjunctivitis. The causa tive agent of this disease was filtrable. The spread was apparently largely through direct contact aided unfortunately in some instances by the methods of ophthalmologic examination and treatment.

Homologous serum jaundice is one of the more important of the entities which have come to light during the recent past. At the present time, it appears that at least 4 per cent of all persons who receive pooled plasma contract serum jaundice and an appreciable number of these cases prove to be fatal. The maledy also follows transfusion of fresh blood although the relative risk is far less. It may prove possible to irradiate plasma with ultraviolet energy and so destroy the novious principle. Otherwise it appears that plasma must be abandoned and use made only of the products of further fractions tion.

Infectious hepatitis is in all probability a separate ontity from serum jaundice and cannot be considered as a new disease, since it has been recognized as one of the more common childhood diseases in this State for many years. However knowledge of its method of spread, through contact, water, and milk, has been considerably in creased during the period we are considering. The evidence now indicates that gamma globulin is an effective prophylactic agent for infectious hepatitia. 3-41

Ornithosis has emerged as a disease which is highly prevalent among some domesticated and wild fowl Certain unpublished studies have demonstrated that a considerable percentage of the domestic ducks on Long Island are infected with the virus of ornithosis, and there is some evidence that a number of persons who have close contact with ducks contract a pneumona presumably caused by the ornithotic virus ¹² Gullsin the area are known to be heavily infected. The virus of ornithosis is very closely related to or is a substrain of the virus of psittacesis.

Within the year, data has been published indicating that actual outbreaks of Q fever may occur in widely separated areas in the United States The nekettsia of Q fever are known to occur in tacks on Long Island 42 44

Also, within the year, the presence of Colorado tick fever has been demonstrated in ticks collected on Long Island 45

Rickettsialpox is the newest disease entity which has been described in New York State **
The remarkable studies on this disease are indeed a credit to the staffs of the New York City Health Department and the United States Public Health Service

There is recent evidence that at least one of the very common types of diarrhea is due to filtrable agents. 57 54

It is also impossible not to refer to the work of Green in Australia who first pointed out the frequency with which congenital defects in the infant are associated with an attack of German measles in the mother during the first half of pregnancy ** The closeness of the association in this country needs much further study, since it is apparently not as great as described by Gregg One is quite unjustified as yet in recommending therapeutic abortion to every woman who suffers an attack of German measles in the first trimester of preg The probability exists that other virus diseases in early pregnancy may damage the fetus. The possibility that the mechanism, by both infection and trauma, is one of interference with the fetal circulation at a critical time in development has been advanced by Ingalls and Gordon 76

Old Problems - Finally it is necessary to point out some of the older problems which are readual and concerning which the recent accretions of wasdom have been sparse. The first of these is rheumatic fever The cause of this malady is still indeterminate It has been noted that recent work has given further support to the hypothesis that control of hemolytic streptococcal infection would go far toward preventing recurrences of rheumatic fover Mortality from rheumatic fever has been steadily declining for half a cen tury, whether or not this is due to the concomitant of diminishing virulence of streptococcal infections is unknown. Although a basic knowledge of rheumatic fever is still to be acquired, it is appar ent that the application of our present incomplete knowledge in the form of organized community programs would be of help in preventing deaths from rheumatic fever

Poliomyelitis is in this same category pestilence which appears chiefly to affect countries which are most advanced in their standard of living and state of samitation is so far not amenable to prevention Treatment has improved within the septennium but is most imperfect Although recent studies have emphasized the possibility of flies and other environmental methods of dissemination, there is every evidence that poliomyelitis is spread primarily through contact 71 Beyond recommending that tonsillectomy be held in abevance during epidemic periods and warning against permitting children from becoming fatigued or chilled, or commingling unnecessarily, there is little practical advice that we can offer to the public which may be expected to reduce greatly the incidence of poliomyelitis

Diarrhea of the newborn must be listed as another of the plagues which is still not under control and which plays its part as an appreciable contributor toward child mortality

Salmonella and shigella infections, despite recent intensive study and definite scientific progress in their detection and classification, continue to prove worrisome to the public health They must be given definite consideration in future programs for communicable disease control

Conclusion

What then of the future? Because of the continuing intellectual efforts which have been so productive of medical progress, we continue to enjoy tremendous declines in death rates, and the control of communicable diseases contributes chiefly to the decline Thus, since 1900, the over-all death rate for the age group ranging from birth to nineteen years of age has declined sixfold in New York State In the five- to nineyear age group in which communicable disease takes the relatively largest toll of life, the combined death rate from the seven most serious communicable diseases is one-fortieth as great today as in 1900 These rates of decline are continuing at this moment at essentially this same downward velocity These phenomenal reductions cannot, of course, continue indefinitely, but merely by applying our present knowledge of communicable diseases more perfectly than it has been in the past, very substantial saving of human life and increase of life expectancy can be achieved within the next few decades

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ARMY VENEREAL DISEASE RATE DROPS AS RESULT OF NEW PROGRAM

A phenomenal drop in the incidence of venereal disease among American soldiers occurred during the past year according to the Medical Department of the Army For the Army as a whole, the decrease amounts to 40 per cent since January 1947 Among soldiers stationed in the United States, the decrease is over 50 per cent for the same period

Chief among the factors responsible for this rapid decline in venercal infection is a new approach on the part of the Army to the problems of curbing the disease. It was left that the greatest results could be obtained by an intelligent appeal to the higher moral sense of the individual. With this in mind, the General Staff established the Department of the Army Venereal Disease Control Council

From the meetings of this council there emerged the well-rounded and integrated program now employed by the Army based on moral, spiritual, psychologic as well as objective, factors. This broadened approach has supplanted prior concepts which emphasized the aspects of prevention, with the implication that the individual was not remiss as long as his illicit sexual relations did not result in Infection

Today stress on the moral reasons for good conduct is imparted to the troops through group and individual education and conferences. Activity programs and planned entertainments help to maintain the wholesome interest of the soldier and tend to keep him off the streets during his off-duty periods

TYPHOID FEVER REACHING A VANISHING POINT IN UPSTATE NEW YORK

Barring unexpected outbreaks, it can be conbdently predicted that typhoid fever will soon become a disease of the past in upetate New York This prophecy seems justified from the fact that more than half of the registored typhoid carriers are over 60 years of age and that far more carriers die annually than develop as a result of reported cases of this disease.

The decline in reported incidence of typhoid fever continued in 1947 although it was less than the 25 per cent decline observed annually for the past decade. With the knowledge based on studies made by the State Department of Health that only 2.9 per cent of all cases of typhoid fever become chronic carriers it is probable that during 1947 not more than one or two new carriers resulted

among the cases reported

At the close of 1947, a total of 465 chronic typhoid carriers were under supervision in upstate New York. Nine new carriers were added to the register and 26 removed Of the 26 removed, 23 died and three were released after complying with the necessary requirements. Of the nine new carriers six were discovered through epidemiologic investigation of sporadic cases of typhoid two, accidentally as a result of routine culturing and one by means of release cultures.

-Health News March 15 1948

CHEST INJURIES

WARRINER WOODRUFF, M D, Saranac Lake

ONE OF THE by-products of war is the opportunity it gives to study a large number of injuries. Probably never before has a medical service been so well organized to take advantage of this material as our own armed forces were in this last war. While the injuries of civilmin practice may be quite different from those seen in combat, nevertheless, certain underlying principles, which proved effective in the care of combat injuries, hold valid for civilian injuries.

Great strides were made in the field of thoracic surgery

follows restoration of functioning thoracic cage, maintenance of clear airway maintenance of an adequate volume of circulating blood, the relief of pain with minimum use of narcotics, prevention of infection, and obliteration of pleural space by early re-expansion of lung

We believe that restoration of a functioning thoracic cage is the first and most important principle to be followed. If there is a sufficient defect in the thoracic cage, so that respiration cannot be carried on efficiently, recovery, if possible, will be delayed and uncertain

TABLE 1 -THORACIC WOUNDS

Author Johnson ¹	Location 20th General Burma	Number of Cases	Deaths 23	7% 7°4			
Shefts and Doud ²	Field and Evacuation Sicily	200 (145 penetrating and per- forating, 55 thoraco-ab- dominal)	18	9 0			
Betts and Lees ²	Thoracic Surgery Team Anzio	164					
Burke and Jacobs	General Hospital E T O	402 penetrating and perforating	3 Le	ss than 3 0			
Harken ^s	Thoracic Center, England	982 (400 major thoracotomies)	ğ	0 9			
Woodruff*	204th General	328 (195 penetrating and per- forating)	ì	0 3			

Table 1 illustrates the experience of six different surgical groups with major thoracic injuries This experience was gathered in all theaters and in all echelons from the field and evacuation hospitals just behind the forward lines, where work was done under great pressure and with limited supplies, back to the thoracic centers in the communication zone, where equipment, supplies, and general conditions were much better we examine these statistics, we cannot help but be impressed with the comparatively small loss of These reports cover 2,300 thoracic casualties with 54 deaths, a mortality rate of 23 per I do not believe any similar series could be compiled from civilian life or from military surgery prior to World War II I should like to dwell for a moment on Harken's statistics, 982 cases of major thoracic injuries, with 400 major thoracotomies, including 32 instances of removal of foreign bodies from the heart b There was not a single death in these 32, and only 9 deaths in his entire series. This is truly amazing. Results like this cannot be due to chance but only to sound surgical principles and sound surgical technics It is these principles which I shall try to present

I should like to approach the problem from the aspect of the goal of treatment of thoracic injuries. We feel that there are six cardinal considerations, which we shall discuss in order as

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The second point is maintenance of a clear airway In health we maintain patent airways by coughing out obstructing matter thoracic injuries we have greater obstruction from blood or mucus and are less able to clear it because of shock and an inefficient thorax If a patient cannot maintain a clear airway, he cannot aerate his remaining lung The most important factor here is a normal and active cough To have an effective cough, the thoracic cage and diaphragm must be sufficiently stable so that a maximum expulsive effort can be made Fractured ribs, lacerated diaphragm, and pain will all decrease the efficiency of a cough must be stabilized and the pain relieved whenever possible Bronchoscopy is the most efficient artificial means of emptying the tracheobronchial tree However, a bronchoscope is not always at hand, and it is difficult to bronchoscope a patient as many times as he should be aspirated Tracheal aspiration by catheter, as described by Haight,7 is a simple technical maneuver, extremely effective, and useful not only in thoracic cases but in any patient who needs tracheobronchial aspira-Moreover, it can be retions (Figs 1 and 2) peated as often as necessary

The third consideration is the maintenance of an adequate volume of circulating blood. In most severe thoracic injuries there is a primary element of shock, even in the absence of gross hemorrhage. Blood loss may be great. A hemothorax of 2,000 cc is as dangerous as an external hemorrhage of the same amount. We feel that



Fig. 1 The method of procedure With the tongue held forward a number 10 catheter is passed through the nares and down to the epiglottis. At this point, as the patient coughs or during the enuing inspiration the catheter is slipped through the wide open glottis. Anesthesia is unnecessary and should never be more than a small amount of 2 per cent pontocaine for the nares and pharynx as the violent cough itself belps to clear the airways

it is sound practice to bring the hemoglobin con tent up to 90 per cent or better by multiple transfusions.

The relief of pain is a fourth important factor in the successful handling of traumatic chests. Repeated intercostal blocks of I per cent processine are very effective and reduce the use of narcotics which have the disadvantage of blunting the cough reflex.

The prevention of infections is the fifth aspect to be considered In taking care of battle casualties we followed the policy of prompt and thorough debridement with primary closure when possible. Debridement cannot handle any infection which has been carried beyond the chest wall. We began penicillin, 20 000 units every three hours, and con tinued it until the pleural space was obliterated In addition we instilled 25 000 units at each thoracentesis. Most patients had received sulfadiarine after injury which we continued only where penicillin was not effective Antibiotics and chemotherapy are not substitutes for adequate surgery and debridement It is not always possible however, to debride completely and close the chest

The prompt obliteration of the pleural space is the sixth consideration. The longer it is delayed the more difficult it becomes and the greater the danger of empyema. The pleura which is thin and clastic at first soon becomes covered by a



Fig 2 The distance that an ordinary catheter will reach. It will extend well down into both main brunchi, and by rotating the catheter and neck it is possible to clear both sides.

fibrinous film which rapidly becomes a fibrous layer with loss of elasticity. Then, even though the space may be obliterated, respiratory excursions of the lung are markedly impaired.

So much for general principles underlying therapy

We have divided thoracic injuries into the following various types—injuries of the thoracic cage without pleurocutaneous fistula—penetrating, and perforating wounds of the chest, hemothorax and tension pneumothorax—injuries to intra thoracic viscera—the lungs, the heart, pericar dium, and great vessels and the esophagus thoraco-abdominal injuries and thoracie injuries involving the spinal cord

Injuries of the Thoracic Coge without Pleurocutaneous Fistula—These are usually the least severe injuries in any series. The most common injury of this type consists of fractured ribs with or without loss of substance. The minor fractures cause little disability although they are painful. One of the most effective ways of treating them is by blocking the intercestal nerveand strapping the chest. If there are multiple fractures with displacement wiring of the ribends will stabilize the chest. In extensive crushing injuries of the chest, traction on the sternum either by rubber bands or by means of weights and a pulley from a Balkan frame may give dramatic relief

In any caved-in chest, it must be remembered that great damage can be done to the thoracic viscera without any open wound. Beck has called attention to the hazards in treating a chest crushed against the steering wheel of a car. Instances have been reported where the heart has received a fatal injury from this type of accident although the extent of the damage has not been apparent until death suddenly occurred two or three weeks later. Any patient who has sustained a crushing injury of the chest and has cardiac symptoms warrants very careful observation and limitation of exertion until scar tissue has had a chance to form

Penetating and Perforating Wounds —By definition, a penetrating wound is one caused by a foreign body entering the chest, a perforating wound is one in which the foreign body has traversed the chest The most frequent causes of the former were bits of high explosive shell. and of the latter, rifle and machine gun bullets A penetrating wound, unless inflicted by a knife or similar instrument, means that there has to be a foreign object still within the body perforating wound there should be no remaining foreign body unless the bullet has shattered or unless bone or clothing has been taken into the chest The lung has great ability to scar in and heal

Two complications of this type of injury are pleurocutaneous fistula and retained foreign Any pleurocutaneous fistula should be occluded as soon as possible A simple sterile dressing is sufficient in most instances ceived one marine from Iwo Jima with a large sucking wound of the anterior chest wall which a Navy corpsman had effectively closed with two safety pins Any temporary method of closing a sucking wound should be used until the patient is out of shock, and at that time it is still early enough to do a debridement and primary closure I think this has a direct bearing on civilian chest casualties, when we may see a patient in the accident ward within half an hour of the time of murv

We removed approximately one third of our intrathoracic foreign bodies. It is difficult to make a rule concerning removal. The question of removal in each instance was decided upon its own merits, based upon the size and shape of the object, its location, and the amount of disturbance it was causing. Figure 3 illustrates how little disturbance may be caused by a retained fragment. In general, we removed no foreign body smaller than 1 or 2 cm unless there was a particular reason for doing so. In certain instances, when a lung was decorticated or an empyema



Fig 3 This is the largest fragment which we removed It was 2½ inches in its greatest diameter and weighed 43 Gm. We first saw this officer twenty-three days following injury. The wound had been debrided and closed in a field hospital, and the patient had been on a transport in the Pacific for two weeks. On arrival the lung was fully expanded, the patient had never had a thoracentesis, and his condition was excellent. It was removed because of its size and not because there were symptoms.

drained, we removed a foreign body which otherwise would have been left alone

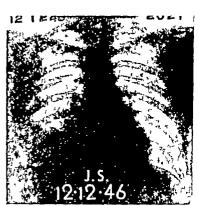
Hemothorax and Tension Pneumothorax -Approximately 90 per cent of those cases judged to have visceral damage had clinically demonstrable hemothorax at the time we saw them War experience has changed the treatment of hemothorax In the past there were certain fallacies connected with hemothorax That blood in the chest seldom clots, that a hemothorax should be left alone and it would absorb, that aspiration of a hemothorax might cause more bleeding from an injured lung, that if a hemothorax were aspirated, the blood should be replaced by air so as to keep the lung collapsed during healing, all of these premises have been proved erroneous We would suggest that, within the first twenty-four hours, a hemothorax should be aspirated only for the relief of dyspnea and to restore the mediastinum to the midline Soon afterwards, it should be removed as completely as possible by repeated daily aspirations without air replacement

It is not always possible to aspirate an unclotted hemothorax. Conversely, it is sometimes possible to aspirate several hundred cubic centimeters of serum from a clotted hemothorax. It is also possible to have an infected clotted hemothorax and yet aspirate sterile serum from another loculation. It is important to know whether a hemothorax has clotted. One simple test, which helps, is to observe whether the aspirated fluid clots after removal. If it does not, then it is fair to assume that the blood has already clotted in the chest, and we are simply aspirating serum. Once it is determined that we have a clotted sterile hemothorax, further treatment



Fig 4. Hemotherax, right base, day following stabbing with a pocket knife.

depends upon its extent and progress as checked by serial roentgenograms Some will absorb mther promptly and the pleural shadow almost completely clear within one or two weeks. If this does not occur, then at the end of three or four weeks thoracotomy should be performed the dotted blood manually removed, and the lung decorticated At this stage it is a relatively simple technical procedure since the fibrinous covering has become sufficiently tough so that it may be peeled from the lung leaving an intact pleura behind. By the end of five or six weeks there is a definite attachment of the plaque to the pleura with fibroblasts and capillanes, and decortication is more difficult and frequently will take the visceral pleura with it Figures 4-9 graphically illustrate the problem of patient J S He was stabbed with a small knufe and did not know that he had been injured until he found blood on his clothing He was admitted to the Veterans Hospital at Sunmount on December 7 1946, (Fig 4), and the small amount of hemothorax present is evident. Four days later this shadow had practically disappeared (Fig. 5) later he had a very dense shadow which proved to be a hemothorax This could only have been due to further bleeding, probably from an inter costal vessel, subsequent to December 12 1946 Repeated aspirations negligible recovered amounts of fluid, all of which were sterile. Progressive films through January 13 failed to show clearing (Figs 6 to 8) Accordingly, the lung was decorticated on January 22, 1947 The last film shows the lung 23 days after the decortication (Fig. 9) There is still a small pneumothorax



Fro 5 Hemothorax completely cleared in four days.

pocket at the apex. This patient has since been discharged and returned to work.

TABLE 2.—RESULTS OF RESPIRATORY STUDIES, PRE AND POSTDBOORTICATION (J. S.)

	5 Days Preoperative 68 2 45		35 Days Postoperative 112 3 51	
Maximum breathing capac- ity, L. Total lung volume, L.				
Differential Lung Function	Right	Left	Right	Left
Minute volume, %	20 15	70 85	86	64
CO-output. %	20	80 80	33 34	67 66
Vital capacity %	11	80	80	70

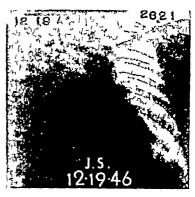


Fig. 6 Fleven days later massive hemothorax from secondary hemorrhage.

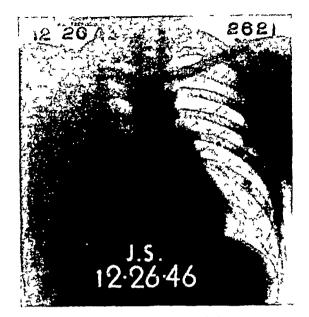


Fig 7 Repeated aspirations failed to evacuate clotted blood

Table 2 shows the result of respiratory studies by Dr George Wright, Trudeau Laboratory, before and after decortication Before decortication, the maximum amount this patient was able to breathe in one minute was 68 L. On February 26, thirty-five days after decortication, the maximum breathing capacity had increased to 112 L, an increase of 64 per cent. Similarly, his total lung volume had increased from 2.45 L to 3.51 L. Bronchospirometric studies show that before decortication, the right lung was accounting for 15 per cent of the oxygen exchange

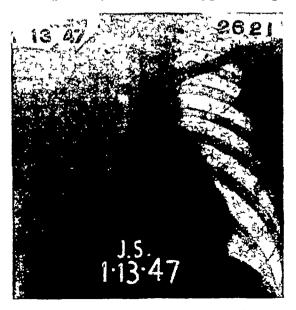


Fig 8 Twenty-five days after secondary hemorrhage with no absorption



Fig 9 Twenty-three days after decortication

and the left lung 85 per cent After decortication the right lung accounted for 33 per cent, the left 67 per cent We hope to have further studies on this man at a later date and expect to find that within a period of months the function on the two sides will be approximately equal. Without decortication we have reason to believe he would have developed a fibrothorax with marked limitation of function

Tension Pneumothorax — This condition results from a bronchopleural fistula. Many of these lesions will close spontaneously, and, in the meantime, an intercostal drainage tube with water seal will tide them over. However, in the presence of a great deal of blood, it may be necessary to resect a rib, put in a large tube, close the wound tightly around the tube, and then attach it to a water seal.

Injuries to Intrathoracic Viscera—We did not have to resect a single lobe, but occasionally at thoracotomy we would remove a bit of badly shredded or necrotic lung. Most injuries healed promptly and with a minimum of scarring. The main problem was to obtain re-expansion as soon as possible. The removal of foreign bodies was very seldom a serious problem. If decortication was necessary, we decorticated the lung first and then, with a soft lung beneath our fingers, were able to palpate the foreign body and remove it by the most direct approach rather than through its wound of entrance.

There were comparatively few wounds of the heart that reached our hospital We had three, one of which furnished our only death, this patient dying of a pulmonary embolus On arrival,

he had already survived one embolus and had an empyema on the right, a hydrothorax on the left and a shell fragment embedded in the wall of the right ventricle. He suffered a second and fatal embolism before he could be conditioned for removal of the fragment Dr Harken removed 32 foreign bothes from the various chambers of the heart without a single fatality civilian life, stab wounds of the heart are sometimes amenable to treatment. They frequently bleed into the pericardium, producing tam ponade. This is a real emergency and must be Cardine tam relieved within a few minutes ponade should be thought of whenever there is a wound which concervably might have involved the heart. The patient may be in considerable shock and very restless but the diagnosis is based on three things (1) a falling arterial pressure. (2) a using venous pressure with distended neck venue and (3) marked diminution in the heart sounds. Fluoroscopy or x ray will show an en largement of the pericardium little changed by the heart beat. With a large aspirating needle the percardium should be aspirated, through the left costomphoid route, which should give immediate relief If tamponade recurs aspirations should be done again and preparations made to open the pericardium as quickly as possible, usu ally by sectioning the fourth, fifth and sixth costal cartilages at the left of the sternum. The wound in the myocardium may be closed by fine interrupted sutures.

I have had no personal experience with treating traumatic ecophageal injuries, but I believe it would be logical to expose the esophagus through a left posterior incision and attempt to repair it

Thoraco-abdominal Intures -In any series of thoracic injuries, the greatest mortality occurs in this group The question of whether to explore the thorax or the abdomen first has to be decided in each case on its own merits. In general the best reported results are those in which it was possible to make the repair through a thoracot-The abdomen may be explored, if necessary either through an enlargement of the orig mul incision or through a separate one. In liver injuries, we had better luck by going in from above, repairing the damage to the liver then through a separate inciden below the twelfth rib passing a Penrose drain up from below extraperitoneally. The diaphragm was sutured from above and the thoracle cavity drained. Others disagree with this and feel that liver wounds should be drained through the thorax Some of our most troublesome problems were those which had been treated this way pre-

Thoracic Injuries Involving the Spinal Cord — These were the most distressing group which we saw Weight loss was excessive. In those that came under our care we treated the thoracic wounds just as though there were no cord involvement and passed on the care of the cord to the neurosurgeons

Summary

This has been a very rapid summary of the problem of chest injuries. Many things have been omitted but I have attempted to outline the principles, rather than give specific treatment for any particular cases.

8 CHURCH STREET

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AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATIONS

The general oral and pathology examinations (Part II) for all candidates to the American Board of Obstetrics and Gynecology will be conducted at Washington, D.C. by the entire Board from Sunday May 16 through Saturday May 22, 1048.

The Shoreham Hotel in Washington will be the bedoughter for the Board Formal paties of the beadquarters for the Board. Formal notice of the exact time of each candidate a examination will be

sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the Shoreham,

Applications are now being received for the 1040 examinations. For further information and applica ion blanks address Paul Titus, M.D. secretari 1015 Highland Building, Pittsburgh 6 Pennsyl-

A DIAGNOSTIC SIGN FOR ANTERIOR TIBIAL VEIN THROMBOSIS

Preliminary Report

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(From the Medical Department of the Bronx Hospital)

THE problem of venous thrombosis, despite recent advances in anticoagulant therapy and surgical therapy, continues to confront us unsolved ¹⁻⁶ Much too often, pulmonary embolism, the dread consequence of unrecognized venous thrombosis, is the first herald of its appearance ⁷ Too often pulmonary embolism is a fatal diagnostic sign of venous thrombosis. The search for improved methods of diagnosis which will lead to the prevention of pulmonary embolism is the only real hope for solution of this problem

In an endeavor to approach the problem from the standpoint of prevention by pre-embolic diagnosis, a diagnostic sign for anterior tibial vein thrombosis is presented. The possibilities of involvement of the deep veins of the anterior muscles of the leg heretofore have not been considered seriously or adequately explored as the site of origin of many of the cases of silent phlebothrombosis. The author believes that this diagnostic sign will enable the clinician to disclose its presence although symptom-free or silent. This sign requires no instruments and is applicable at the bedside

The diagnostic sign consists simply of passively extending the foot 45 degrees or less, depending on the maximum painless mobility of the ankle joint and, if this elicits no pain in the patient, plantar flexing the toes while the foot is held in extension by the examiner's hand. At present the author's practice is to combine these two movements into one, as illustrated in Fig. 1, by grasping the toes, flexing them in a plantar direction, and automatically extending the foot up to 45 degrees or less at the same time

The sign is positive and reveals evidence of thrombosis of the anterior tibial vein if the maneuver elicits pain anywhere just lateral to the anterior crest of the tibia, but especially at a point three inches above the distal end of the tibia, where the position of the anterior tibial vein is most superficial in its course It is at this point that foot extension produces maximum compression of the anterior tibial vein This pain can be elicited repeatedly so long as thrombosis of the anterior tibial vein persists, although the con-The author dition otherwise is symptom-free shall henceforth refer to this sign as the "foot extension" sign

Experimental Study —In order to test the mechanics of the foot extension sign, the author

devised, with the help of others, "artificial vein" segments connected with specially devised gages. The "artificial vein" was inserted in the place of the collapsed anterior tibial veins of a leg of a cadaver, and the foot extension test was tried in order to determine pressure produced on these vein segments (Fig. 2)

This "artificial vein" segment, filled with water and attached to the gage, was inserted in the position of the collapsed anterior tibial vein, at a point just proximal to the site where the extensor hallucis longus and the tibialis anticus muscles cross the anterior crest of the tibia. approximately three inches above the ankle application of the foot extension test produced pressure which forced the liquid up into the tuberculin syringe gage Three readings obtained The variations in the readwere 28, 18, and 8 ings were due to the fact that the cadaver muscles did not completely return to position, and, after the third test, further tests could not be carried When the vein segment was artificially compressed so as to expel all the water filling the segment, the maximum reading was 30 would indicate that the foot extension maneuver resulted in compression of the artificial vein wall to the extent of obliterating 14/15 of its lumen would be expected that such pressure on a thrombosed vein would certainly be sufficient to cause pain

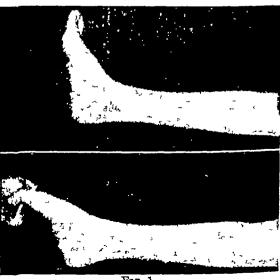
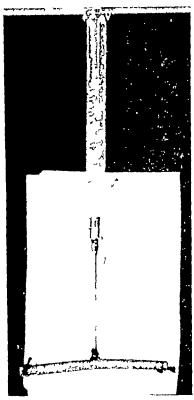


Fig 1



Fro 2 A piece of gutta percha tubing 2% inches long and 1/a moli in diameter is tied at the ends with saik thread In the center there is a narrow solid block of rubber vulcanized to the surface of the tube. It is just wide enough to seal the beveiled tip of the 17-gage hypodermic needle completely. This per miles the tip of the needle to pierce the tubing with no lenkage and prevents the piercing of the opposite side of the tubing during compression of compression of the tubing filled with water forces the liquid through the needle opening and up into the tuber culin syringe gage. Readings on the syringe gage are made from the side calibrated into one hundred divisions.

Case Reports

Case 1—G K. a 42-year-old white woman, was admitted to the hospital because of pain in the left chest and hemoptysis. She had a significant part history of rheumatic heart disease

first discovered during her first pregnancy, and for which she was aborted legally when gravid the second time. During five years prior to her present filnces she was listed on the records of the writer as a class one-B cardiac, with mitral insufficiency and milral stenosis with regular sinus rhythm symptom-free, having no difficulty in reaching a third floor walk-up apartment.

During February, 1946 the patient developed chills and fever which proved to be subscute bacterial endocarditie when two positive Streptococcus viridans blood cultures were obtained. Cardiac examination at this time revealed, in addition to mitral insufficiency and mitral stenosis, aortic insufficiency The heart rate was regular with a tachycardia consistent with elevation of the temperature. During six weeks that followed the establishment of confirmed positive 8 vindans blood cultures the patient received a total of 79 000 000 units of penicillin with the maximum twenty four bour dose never exceeding 2.4 million units. After peni cillin therapy was instituted blood cultures were repeatedly found to be negative On April 22 1946 the patient was discharged as cured.

At this time, the patient's cardiac state was changed as follows The murmur of aortic insuffi ciency was more marked, and the circulatory dy namics of this murmur such as pistol-shot brachials, corrigan pulse and high pulse pressure not previously noted, were now unequivocably present. In addition to these signs it was found that the pulsations of the anterior tibial artery were transmitted to the examining finger just above the site where the extensor hallucis longus muscle crosses the anterior crest of the tibis and just lateral to this edge about three inches above the ankle joint. It is noteworthy incidentally that a palpable anterior tibial artery to the knowledge of the writer has never before been described as a finding associated with sortic insufficiency

This patient's cardiac reserve diminished progressively following discharge until after spending a summer at the beach she returned in a state of chronic congestive failure requiring digitalis and mercuhydrin at bed rest. In September, 1946 the patient developed a left posterior tibial artery occlusion due to embolism. The effects of the embolism were weathered with the establishment of adequate collateral circulation following the use of a thermo-electrically controlled heat cradle papaverine, and other adjuvant drugs as indicated. On October 15 1946 the patient was seized suddenly with pain on the left side of the chest and developed hemopty ais. On examination it was decided clinically and later confirmed by cliest x ray at the Bronx Hospital that the patient had had a pulmonary embolism, probably from a bland thrombus in the deep leg veins. The heart was not incriminated because the heart rate was regular and because there were no signs indicating pathology in the right heart for the development of thrombi The usual examination failed to reveal any evidence of deep vein involvement of the lower extremities. Silent phlebothrombosis was diagnosed and the patient was placed on dicumarol therapy. The necessity for oxygen

therapy and daily prothrombin determinations led to the patient's readmission to the Bronx Hospital on October 18, 1946

While the patient was at the hospital, the author examined the extremities at least twice a day ing one of these examinations, it occurred to him that tensing the anterior leg muscles would bring pressure on the anterior tibial veins and on other deep veins imbedded in the anterior muscle mass He thereupon extended the foot as far as it would go without causing pain in the ankle joint and plantar flexed the toes as indicated in Fig. 1 This latter maneuver had the effect of still further tensing the anterior muscle group, with the large toe serving to tense the extensor hallucis longus The patient winced with pain which she described as being at a point just lateral to the anterior crest of the tibia and just proximal to the upper edge of the tibialis anterior muscle as it crossed the anterior crest of the tibia This procedure had the effect of markedly compressing the anterior veins at this point as demonstrated by the special study previously described the examiner released the foot and put light pressure over this site, marked tenderness was elicited, and the pulsations of the anterior tibial artery were felt This ruled out the possibility of embolization to the anterior tibial artery as an explanation for the pain elicited by the foot extension test This pain could be elicited for several days by the foot extension test along with tenderness over the site produced by direct gentle downward pressure When the test was no longer positive, the tenderness from direct pressure vanished. Throughout this period, the calf muscles bilaterally were negative on examination, and Homan's sign failed to elicit evidence of involvement of the deep veins of the calf muscles

The patient continued on disumarol for three weeks. When all evidence of tenderness in the anterior muscles of the right leg disappeared, and the patient's symptoms such as fever, tachycardia, pain in the chest, and hemoptysis subsided, disumarol was discontinued. The patient was discharged a week later when no additional evidence of bland venous thrombosis developed. No further episodes of pulmonary embolism occurred from the time the patient left the hospital until the time of her death from congestive heart failure six weeks later at her home. Efforts to obtain a postmortem examination were unavailing

Summary of Laboratory Data During Last Hospital Stay—An x-ray of the chest on November 16, 1946, showed irregular, patchy, increased densities at the right base, representing small infarctions. The appearance of cardiac shadow was compatible with combined mitral and aortic disease. The electrocardiogram on November 12 showed no evidence of myocardial damage Prothrombin levels daily from October 19 to November 13 varied usually between 30 and 50 per cent. Two blood cultures were sterile

On October 19, the blood chemistry tests showed glucose, 76, urea nitrogen, 163, nonprotein nitrogen, 40 On October 31, the total protein was 60 Gm. per cent, the albumin was 325 Gm. per cent, globulin was 275 Gm. per cent In the urinalyses,

the three specimens varied in specific gravity from 1 005 to 1 014 and were negative except for a trace of albumin. The blood counts on October 19 showed hemoglobin, 88 per cent, red blood count, 4,520,000, white blood count, 13,000, with 83 per cent polymorphonuclears, 3 per cent band forms, 2 per cent eosinophils, 2 per cent monocytes, and 10 per cent lymphocytes, on October 28, the count showed hemoglobin, 80 per cent, red blood count, 4,500,000, white blood count, 7,700, polymorphonuclear leukocytes, 67 per cent, 1 per cent band forms, 2 per cent monocytes, and lymphocytes, 32 per cent

Case 2 —L. S, a 35-year-old white man, a physician, complained of "phlebitis" first noticed when, after entering his car, he pushed out his clutch for the first time in the morning The pain in the leg became worse, and the physician presented himself for examination Examination revealed a negative Homan's and a positive foot extension test site of pain elicited by extending the foot 45 degrees and then plantar flexing the toes, an area of warmth and exquisite tenderness and slight swelling was felt There was no evidence of rubor A diagnosis of thrombophlebitis involving the anterior tibial veins Despite the presence of tenderness in the calf muscles, the Homan's sign was negative.

When pain in the leg was present on awakening the following morning, the physician decided to treat his leg by rest, elevation, and sedatives. By the fourth day, signs and symptoms subsided sufficiently to permit the physician to resume his practice. All signs and symptoms completely subsided by the seventh day.

One must conclude in this case that whether or not thrombophlebitis was present in the veins of the calf muscles, definite clinical signs pointed to its presence in the anterior tibial veins. Indeed, it would not be unusual to expect thrombophlebitis to involve both anterior and posterior tibial veins. The writer suspects that this occurrence is not rare but is rarely recognized.

Controls

The author selected fifteen controls, three of which were cases of aortic insufficiency. The three cases of aortic insufficiency with evidence of palpable anterior tibial arteries failed to respond to the foot extension test, thus ruling out the possibilities that the dynamics of aortic insufficiency produced expansile changes in the anterior tibial artery which would give a false positive foot extension test. All the controls are summarized in Table 1. All responded negatively to the foot extension test.

Discussion

The writer considers the omission of a search for thrombosis of the veins of anterior leg muscles unfortunate Holden, discussing the treatment of deep venous thrombosis, reveals that in his series of cases 16 out of 31 had pulmonary infarcts before the diagnosis was made ⁷ This high percentage of errors is not unusual Could

TABLE 1

Name	Sex	Age	Occupation	Condition	Bilateral Foot Extension Sign	Bilateral Homan s Sign
L.A.	F	5G 57	Housewife	Normal	Nezativo	Negative
P R A, D	M	57	Cutter	Arteriosclerosis oblitarans	Negative	Negative
À. D	M	36	Engipeer	Normal	Negative	Negative
M D	M M F		Housewife	Left ovarian ovat	Negative	Negative
A D M D H R	ř	72	Housewife	Normal	Negative	Negative
M D H R E M	ř	90	Housewife	Normal	Negative	Negative
i si	ir	39	Salesman	Normal	Negative	Negative
E.T	7! FI	20 32 29 32 36	Engineer	Aortic insufficiency	Narative	Negative
R. M	F	60	Housewife	Normal	Negative	Negative
R. M II. P	F	48	Bookkeeper	Lupus erythematoris, aorti		TI-GARATT.
				insufficiency	Negative	Negative
8. M. A. B.	M	37	Broker	Fatigue syndrome	Negative	Negativ
A. B.	M M M	43	Operator	Essential hypertension	Negative	Negative
JP	Ñ	60	Real Estate	Essential hypertension	Negative	Negative
FP	Ÿ	33	Housewife	Fatigue ayndrome	Negative	Negative
ġ Ř.*	Ė	49	Housewife	Aortio insufficiency phlobo-		
	•		2104201110	thrombods	Negative	Positive

When S. B, expired a postmortem examination corroborated the positive Homan salan.

it not possibly be related to the failure to consider the occurrence of anterior tibial vein thrombous? The anterior tibial veins have been granted no physiologic basis for immunity from thrombosis. They also deserve no immunity from the spotlight of scientific investigation. The fault may not entirely rest with the clinicians faced with the simple fact that anterior tibial vein throm bods is alent most often when it does occur, and that pathologists, with one exception known to the writer, never even bothered to investigate the possibility.

A recent pathologic study of 351 autopases with emphasis placed on the question of deep leg vein thrombosis, failed to include examination for involvement of the anterior tibial veins. Frykholm, in 1939 in 24 cases of pulmonary embolism found no evidence of anterior tibial veins with the total vein thromboss. The writer could not blear what types of cases were involved in this series. It would obviously be of value to know whether the cases were cardiac postoperative post partium, or infections etc.

In 1940, Frykholm writing in English for an American publication again summarized his work on the same 24 cases of pulmonary embolism but the time the impression was unintentionally given that 139 were studied 10 The identical incidence of thrombons in both articles indicates that 139 instances of thrombosis were found in 24 cases in which 42 legs were examined thrombons often occurs bilaterally in the lower extremities as revealed by Frykholm's own studies the number of uncontestable cases drops to 18 unless the six remaining of his 24 cases were one-legged amputees. The English reading medical public was mustakenly overimpressed with the aignificance of Frykholm's article. The pathologic evidence thus far submitted by no means settles the problem

In 1942, Starr Frank, and Fine, discussing the venographic diagnosis of thrombophlehitis re-

ported among their cases one of anterior tibul vein thrombosis 11 This occurred in a case of pulmonary embolism after a right inguinal herniorrhaphy The first pulmonary embolism on the twelfth postoperative day was shown by venography to be due to deep vein thrombosis of the left leg for which a femoral vein ligation just distal to the profunda femorus was done. When on the twenty third postoperative day, a second pulmonary embolism developed, venograms were again taken of both legs. On the right leg an absence of filling in the anterior tibial veins was considered to be due to thrombons After the right femoral vein was ligated, the patient encountered no further embolic episodes Considering the fact that after the second pulmonary emboham, venography showed all yeins patent in the left leg and all but the anterior tibial vein patent in the right leg, it is reasonable to conclude that the diagnosis of anterior tibial vein thrombosis was justified and accurate.

When one considers the effects of neglecting the question of anterior tibial vein thrombosis in relation to pulmonary embolism and the possible needless loss of life entailed then one does not hesitate to challenge present-day teachings on the subject of venous thrombosis of the deep veins of the legs.¹³ It is not enough to test simply for thrombosis of the plantar veins and the deep veins of the calf muscles. One must rule out as well the possibility of thrombosis of the deep veins of the anterior leg muscles with special emphasis placed on the practically ignored possibility of anterior tibial vein thrombosis.

Summary

In this preliminary report, it is the purpose of the author to present a simple diagnostic sign as a clinical aid in the diagnosis of anterior tibial vein thrombosis. Two cases of anterior tibial vein thrombosis diagnosed by a positive reaction to thus sign are cited. Negative controls are thou lated. The possible significance of the neglected.

question of anterior tibial vein thrombosis in its relation to the problem of pulmonary embolism is discussed

The incidental finding of a relationship between palpable anterior tibial artery and aortic insufficiency is noted in four cases Palpability is just lateral to the anterior crest of the tibia about three inches above the ankle

The incidence and relative importance of anterior tibial vein thrombosis await the light of further extensive pathologic as well as clinical investigation It is hoped that application of the diagnostic sign for anterior tibial vein thrombosis (45 degrees or less passive foot extension, combined with plantar flexing of the toes) will aid in the ultimate resolution of this problem

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CLEANLINESS SHOULD RATE WITH THREE R'S, SAYS HYGEIA EDITOR

"Children should get the same credit for knowledge of health, hygrene, cleanliness, and good health habits as they get for reading, writing, and arithmetic," Morris Fishbein, M.D., Chicago, says in an editorial in the current issue of Hygera, the health magazine of the American Medical Association

Outlining a program for a cleaner America, Dr Fishbein points to the control established over leprosy as one indication of the manner in which cleanliness alone can control an infectious disease

"We must train children from the earliest period of awareness to proper habits with relation to cleanliness," he observes "Cleanliness and personal hygiene should be integrated in the curriculum of the schools "

A program for a clean America means "the application of plenty of soap and water—the greatest of all the cleansers—to our surroundings and to ourselves," he states

"The human body is to a great extent a self-regulating mechanism. The skin has great powers for disinfecting itself, and it has been proved that the physical removal of foreign material, including germs, from the skin is important in order to permit the self-disinfecting power of the skin to Germs are highly susceptible to the action of soap

"More than 20 years have passed since workers at the University of Nebraska conducted some experiments on the cleaning of clothing. A clean body requires clean clothes. They counted carefully the number of germs on underclothing and

other clothing near to the human body average count of 400,000 germs per square inch after one use, the number of germs on a square inch of an undershirt increased to 10,000,000 after the shirt was worn six times When the shirt was put through a modern laundry process, including hot water and soap, the germ count was reduced to 1,000 or less in that area.

"Modern experts have much to say about the There is a feeling psychologic effects of cleanliness of well-being that follows a good bath knows the lift that comes after a bath followed by the putting on of clean clothing Indeed, the psychiatrists who are concerned with disordered mental states judge to some extent the character of the disturbance in the patient who insists not only on soiling himself but on wearing soiled clothing

"Recent scientific research has been concerned also with the cleaning of eating utensils World War I studies made in some of our great camps proved that hand-to-mouth infection and infection from soiled eating utensils were the chief routes in the spread of respiratory diseases such as coughs, colds, and pneumonia, which are the second greatest cause of disability and absenteeism in industry Hence, there are plenty of reasons for introduction of our modern processes of cleaning kitchen utensils and dishes Moreover, the psychological officials and dishes distributed by the psychological officers of the psychological officers of the psychological officers of the psychological officers of the psychological officers of the psychological officers of the psychological officers of the psychological officers of the psychological of the psychological officers of the psyc logic effects on digestion of meals served with utensils that are immaculate are in startling contrast to the effects of these not properly cleaned "-AMA News, March 5, 1948

CORONARY ARTERY DISEASE IN OLDER PATIENTS

GABRIEL F GRECO, M D Ozone Park New York

CORONARY artery disease is an important cause of disability and mortality in the older patient. The number of cases suffering from coronary artery disease has continued to in crease especially in the last thirty years with fatalities reaching the highest percentage on record 8.5 per cent of all deaths. It is a disease which occurs mostly after forty, more frequently between fifty and sixty.

Master, in a discussion of the many factors involved in the incidence of acute coronary artery occlusion, places the number of cases as high as one million yearly 1 White estimates that 37 per cent of patients with organic heart disease have coronary artery involvement with more or loss varying degree of coronary sclerosus and relative coronary insufficiency. When we consider that heart disease is the greatest killer causing 28.5 per cent of all deaths, and that there are according to surveys between four and eight million people afflicted with heart disease in this country, we can well realize the magnitude of our problem. It is obvious that with the increased advances in medical knowledge there will result a lengthened span of life and a proportional in crease in the incidence of coronary artery disease This problem will multiply with the passing years threatening us with a greater increase in disability and mortality

It is our responsibility to shorten and prevent invalidism by the early recognition of the symptoms of coronary artery disease in those who are fortunate enough to survive the initial attack In acute coronary thromboes with myocardial infarction, Levine gives the immediate mortality between 15 and 25 per cent. After recovery duration of life varies from three to fifteen years or more. In angina, although instant death could occur at any time, a patient may live over twenty years. It is possible therefore by our present methods of treatment to safeguard the hearts of those surviving cases suffering from acute coronary insufficiency by preventing prolonged anoxia, which too often results in injury and death Davis states that surveys of necropeses show that 70 per cent of men over fifty and women over eaxty have some form of coronary atherosclerosus that 100 per cent of men and women over seventy show some evidence of this disease, and that 45 per cent of all deaths of people over fifty are due to coronary athorosclemsis.

Presented at a meeting of the American Gerlatric Society June 7, 1947 Coronary artery disease in older people is dependent on atherosclerosis of the coronary arteries which may be only a part of a generalized process of arterial degeneration. It occurs three times more frequently in mon than in women theredity explains the greater incidence in certain families and in the male sex. However, other factors may play a part. Smoking increased stress and strain, and the increased tempo of our modern life may so overload an already anatomically defective coronary arterial tree as to cause coronary insufficiency and collapse simply from overuse and abuse.

Favoring herodity and vascular vulnerability are many factors which, with a favorable set of conditions such as hyperplycemia and hyper cholesterolemia lay the foundations for atherosclerosis. The intima of the coronary artery at birth is thicker in boys than in girls, and this condition and this relationship continue with growth In this thickened intima connective tissue forms with small and large wandering cells which become loaded with fat. Tissue around the fat-laden cells becomes necrotic. At this stage there may be fragmentation of the intima with loss of elasticity. In this subintimal mass of fat droplets, wandering cells, and necrotic tissue there occurs a deposit of cholesterol crystals with precipitation of calcium salts, forming calcified plaques Part of this necrotic material may break through the intima and travel down the coronary arternal tree causing sudden block and death

With cholesterol playing such an important role it becomes necessary to control hyper cholesterolemia. This is rather difficult, because there is an unknown personal factor which allows some individuals to utilize cholesterol more efficiently than others. It is a known fact that among the Chinese with low cholesterol detathere is negligible atheroselerosis of the coronary arteries. In obesity and hypothyroid states especially if associated with diabetes, renal disease and vanthomatoses, the hypercholesterolemia will not only need diet control but effective treatment of the associated diseases.

Coronary artery disease even though ad vanced may present no diagnostic signs or symptoms. It is not surprising to find at autopsy in older people, dying from other causes marked coronary involvement without symptoms. Generally, we can consider two groups

1 Atherosclerosis of the coronary arteries with narrowing of the lumen of either coronary

artery giving the following clinical patterns asymptomatic group, anginal syndrome, and cardiac insufficiency with signs of left- or rightsided failure, paroxysmal dyspnea, and paroxysmal pulmonary edema

Coronary artery atherosclerosis with occlusion or blockage of a coronary artery with atheroma or blood clot resulting in prolonged ischemia, necrosis, and infarction

These classical patterns will now be discussed Symptoms in both groups, whether secondary to narrowing or occlusion of the coronary lumen. will become evident because of an imbalance between coronary arterial blood supply and myocardial requirements resulting in anoxia, insufficiency of the coronary circulation, and sud-If the collateral circulation comes to den death the rescue and the exciting factors placing excessive demands on the coronary circulation are controlled, the anoxia may be transient, damage to the myocardium slight, and recovery assured It is in this latter group that we can confidently cut down mortality and disability in spite of the rising incidence of this disease in older people

Atherosclerosis with Narrowing of the Lumen

Asymptomatic Group —In these cases the absence of clinical symptoms is possibly due to the marked collateral circulation which permits satisfactory myocardial blood flow at rest and on exertion in spite of extensive coronary artery In this group there may be no characteristic findings, even though calcified coronames may be demonstrated on x-rays

Angual Syndrome—Here the diagnosis rests mainly on the patient's history The pain is substernal, may originate in the epigastrium and extend upward giving a sense of constriction of the chest It may extend down the left shoulder, arm, and fingers following the ulnar nerve distnbution Less frequently, the pain may radiate to the neck, laws, and teeth The pain is characteristically precipitated by an exciting factor such as exertion, emotion, eating or chilling and may disappear with rest The type of exertion may be minimal or maximal depending on the relationship of coronary artery disease and myocardial insufficiency resulting from sudden de-Pain varies from a heaviness to a crushmands There may be pallor, even syncope, ing feeling sweat, and fear of impending disaster aminations may be negative, and the history alone may be of importance in establishing the The responsibility here is great We must be sure of the diagnosis, because it carries with it the likelihood of sudden death Nitroglycerin relief is no criterion for diagnosis of the anginal syndrome, because this drug also

relaxes intestinal, gastric, and biliary spasms which often simulate the anginal syndrome

Patients with the anginal syndrome will have to readjust their entire philosophy of life to conform to their decreased myocardial reserve Avoiding evertion, excitement, and overeating will decrease coronary load Nitroglycerin is of help for pain and may be repeated as often as Quinidine sulfate is indicated for extrasystoles and will prevent ventricular tachycardia and ventricular fibrillation In thyrotoxic heart with angina, thyroidectomy, when permitted, or thiouracil has produced excellent In severe recurring angina where these measures fail, surgery has been attempted to increase local myocardial blood flow and to interrupt painful stimuli by removal of the cervical or dorsal gangha

Coronary Artery Disease with Narrowing and Resulting Cardiac Insufficiency —Here cardiac insufficiency may result because the heart, suddenly deprived of adequate blood flow, finds it hard to pump the blood from the venous to the arterial side through the pulmonary circuit Symptoms and signs will become evident depending on whether left- or right-sided, or both, failure occur In left-sided failure, there results stasis in the pulmonary circuit In right-sided failure, there is stasis in the systemic circuit left-sided failure we find dyspnea, often of the parovysmal type, increasing fatigue, orthopnea with basal pulmonary congestion, and decreased vital capacity The pulmonary edema may occur as a single episode or as a series of paroxysmal If these attacks continue without treatment, more signs of right-sided failure develop with distention of neck veins, liver enlargement, and peripheral edema Circulation time is prolonged, intravenous pressure rises, and cyanosis becomes evident It is important to differentiate between the two, because treatment will vary

In left ventricular failure, morphine sulfate will curtail demands on the left ventricle by depressing anxiety and restlessness and by diminishing the blood pressure and the cough reflex, thereby reducing the tendency to pulmonary congestion Aminophylline in dextrose solution will eliminate bronchial and coronary spasm, reduce pulmonary edema, and supply ready, available food to the In an emergency where distressed myocardium sudden failure calls for immediate action, strophantin given slowly in patients who have had no digitalis will often produce miraculous re-In increased venous pressure, a phlesults botomy often is life-saving, especially when cyanosis deepens, when the dyspnea and orthopnea are severe, and the jugular veins are prommently engorged

In right-sided failure, digitalis is specific. Digitalis in right-ended failure will increase the functional capacity of the heart by slowing rapid rate, restoring regular rhythm and increasing ventricular systole Digitalis will diminish the circulating blood volume lessen engorgement, and materially diminish the size of the heart. It will increase vital capacity, diminish the size of an engorged liver, and alleviate meteorism. By so doing in right-sided failure due to coronary artery disease, digitalis will diminish the coronary load, and it will allow the heart to work much less by working more efficiently. When bed rest and diritalis do not overcome the edema even in spite of a salt free diet, then mercurial diuretics and drugs of the xanthine group may be used. To augment diuresis, morganic salts may be used, ammonium chloride being the salt more frequently used

Atherosclerosis with Occlusion

In occlusion of the coronary artery, the signs and symptoms will depend on the size and collateral supply of the occluded artery Death may be sudden if the occlusion is sudden or the collateral circulation inadequate. The blocking may be the result of atheroma, blood clot or progressive narrowing with occlusion

The pain here is substernal epigastric or precordial, and sudden in onset, occurring on exertion, as in angina, or at rest. Pain here is more prolonged severe crushing unrelieved by rest or nitrites. The blood pressure falls with symptoms of shock. The heart sounds may be faint with gallop rhythm Leukocytosis occurs in the first eight hours, with fever following in the next twenty four hours. There may be a pericardial friction rub which is occasionally audible but transient. After three days there is an increase in the sedimentation rate. There may be an atypical picture without pain Cardiac arrhyth mias may be present, most prominent among these being premature beats, auncular flutter auncular fibrillation, ventricular extrasystoles, ventricular tachycardia and ventricular fibrilla tion.

A single negative electrocardiogram does not rule out the diagnosis of coronary atherosclerosis with occlusion. The patient's history and clinical course should always be of paramount importance in such a case. An electrocardiogram however, showing a patient of acute myocardial infarction in a patient with no symptoms and no coronary history should never be ignored. Repeated serial studies of the three limb leads and of at least six precordial leads in older patients with coronary patterns or coronary history are of importance for they will reveal much in formation as to location, extension, and resolution

of the infarction Burch and Winsor have assembled facts which simplify the interpretation of the various electrocardiographic patterns, the most common being the Q1T1 type, the Q3T3 type the mixed type, and the anteroseptal, anterolateral and postcrolateral types.

The temporary obstruction of a coronary artery produces temporary ischemia of the myocardium which results in temporary T changes. If the obstruction is released, the electrocardiogram returns to normal. If not, the prolonged ischemia causing T-wave changes will result in injury to the myocardium. This injury releases currents shifting the ST segment upward or downward resulting in elevation or depression of this seg-If ischemia is improved before permanent damage is established, these electrocardiographic changes revert to normal If occlusion persists. then T wave changes due to ischemia persist and so do ST-eerment changes due to currents of In addition, there are recorded effects due to necrosis of muscle tissue which are evi denced by permanent QRS changes, consisting of an absent or low R wave (less than 1 mm) and the presence of Q waves. As repair takes place the current of injury disappears first, with ST segments returning to the isoclectric line. The T wave changes of ischemia may disappear later as the collateral circulation improves Changes due to necrosis of muscle tassue mainly absence of the R waves and the presence of Q waves, are the last to disappear, if at all It is apparent why a single electrocardiogram is not sufficient These characteristic changes in patterns of ischemia injury, and death of muscle tissue are only detected in senal studies

In treatment, bed rest from four to six weeks with complete relaxation is essential to insure a firm scar in all parts of the infarct It will prevent scar tissue breakdown necrosis myomalacia and aneurysmal dilatation with rupture pain oxygen and opiates should be given at first then demerol and papavenne. After pain is controlled, sedatives are indicated to promote relexation Anticongulants have been advised for the immediate attack and also for the prevention of recurrent episodes, but they are still in the experimental stage and must be used under constant supervision. Quinidine sulfate is indicated for ventricular extrasystoles and for the prevention of ventricular tachycardia and ventricular fibrillation. After six weeks there comes a period of months of wise management. It is during this time that the patient's life and the patient's philosophy are readjusted gradually to conform to his myocardial reserve

Conclusion

With the span of life lengthening there results

an increase in the generation of older men and a proportional increase in the incidence of coronary artery disease

The magnitude of this problem challenges us to evert constant vigilance for the early signs and symptoms of coronary artery insufficiency. Early diagnosis will allow us to institute early treatment. Prevention of prolonged anoxia will result in less injury and may ward off actual necrosis and death of muscle tissue. Thus with these methods of detection and control, limited though they be, it will be possible definitely to

lower the rate of disability and the rate of mortality in the older age groups afflicted with coronary artery disease

114-08 LINDEN BOULEVARD

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AMERICAN COLLEGE OF CHEST PHYSICIANS MEETING SCHEDULED FOR JUNE

The Fourteenth Annual Meeting of the American College of Chest Physicians will be held at the Congress Hotel, Chicago, Illinois, June 17 to 20, 1948 An interesting scientific program has been arranged for this meeting, and speakers from several other countries are scheduled to appear, according to an announcement by Murray Kornfeld, executive secretary

A. M A CALLS FOR EMERGENCY NIGHT MEDICAL SERVICE

The American Medical Association has called on county medical societies to meet the public demand

for emergency medical service at night

"From many sections of the United States," says an editorial in a recent (March 6) issue of the Journal of the American Medical Association, "complaints have come lately that persons who have called physicians late at night have been unable to secure attendance from those whom they considered their family physicians or from specialists or, indeed, from any physician"

The American Medical Association says that large county medical societies or urban groups should maintain a physicians' telephone exchange which would take the responsibility for locating physicians if response is not made to the ringing of

the telephone in the home or in the office

The solution is simple and practical, requiring only a minimum of community organization. A number of county medical societies already maintain a physicians' telephone exchange where doctors' calls may be received and doctors located if their office or home telephones do not respond. Such an exchange can be utilized, as at night or on holidays, simply by furnishing the exchange with a list of physicians who are able and willing to make night calls. Such physicians would probably include the younger general practitioners, newcomers to the community, and others in general practice. If such a roster were available, and its availability

widely publicized, night calls for medical service would soon gravitate to this center, and the patient would be assured the services of a physician

Under such a system the necessity for calling many doctors would be eliminated. Two calls at most would be necessary. Where there is no physicians' telephone service, it might be possible to have the hospitals cooperate by handling such night calls.

The Medical Society of the District of Columbia and the Milwaukee County Medical Society have found such a plan practical, as have a number

of other societies

By this simple and practical expedient, which is doubtless in effect in modified form in a number of communities, the sick can be served and the medical profession can redeem its pledge of unselfish public service. It is highly important that where such arrangements exist they be brought to the attention of the lay people in the community through appropriate public channels, not once but repeatedly, to keep the shifting populations well informed

to keep the shifting populations well informed
Few problems in the field of medical service have
aroused so much public discussion. Whether resentment against physicians is justified or not, it
does harm. The solution for this problem is so
eminently simple and would reflect so favorably
upon physician-patient relationships that medical
societies everywhere are urged to give it serious

consideration immediately

MYCOTIC INFECTION IN GANGRENE OF THE LOWER EXTREMITIES

SAUL S SAMUELS, M.D., New York City

(From the Department of Peripheral Arterial Diseases Stuycesant I olyclinic Hospital)

THERL are two factors in the development of I peripheral gangrene, and one of these has been sadly neglected I refer to infection, which is probably the most frequent precinitating cause of gangrene While in almost every case there is an underlying arterial deficiency in the extremity due to arteriosclerosis obliterans in varying degrees, it is unfortunate that so much effort has been wasted in attempting to improve the arterial circulation rather than to attack the basic, underlying factor in the development of gangrene namely, infection As a result treatment has been concerned mostly with various drugs mechanical apparati operations, and other futile means of 'improving" the col lateral circulation in the affected leg resulting in unsatisfactory attempts at conservative treat ment and unnecessary amoutations

A few years ago I described the pathogenesis of diabetic gangrene indicating the importance of pyogenic infection in its development and suggesting a new approach in treatment that resulted in a lowering of the amputation rate and an increase in the number of cases of diabetic gangrene saved from amputation. At the outset of these studies it seemed sufficient to direct all efforts toward the pyogenic organisms. To accomplish this purpose ascelhoramid was applied locally and penicillin and the sulfadrugs systemically. The result was an on couranner number of successful cases.

It was soon found however that a certain number apparently did not respond This was particularly true in those cases with a poor or absent oscillometric reading at the ankle level Another interesting observation was the fact that almost all of these difficult cases presented in addition to the acute pyogenic infection a a slow, progressive almost chronic course accompanied by a peculiar sour odor quite different from that of ordinary gangrone Recalling that a great percentage of these cases originate as my cotic infections interdigital and otherwise. I felt that the end result was undoubt edly a mixture of the original mycotic infection plus secondary pyogenic infection. I also felt that if the niveotic aspect of the infection could be attacked much better results could be obtuned in cases previously coming to amputation

In the treatment of athlete s foot and simular fungus infections it has been observed that the most efficient funguedal agents are the salts of the higher fatty acids. These include the salts of propionic acid underviente acid and the recently developed salts of caprylic acid. The commercially available preparations of these fungicidal agents are dispensed in a tale base which is irritating to open lesions.

Case Reports

Case 1—H M a man aged 74 was first seen on November 4 1044 at which time there was edemand deep cyanosis of the left foot with beginning gangreno of the left big toe. His right leg had been amputated above the knee a year previously for gangrene of a single toe.

The underlying arterial disease was arteriosclerosis obliterans Despite conservative measures for improving the colluteral circulation in the left leg and foot small blisters formed at the base of the left big toe which within a few days became gangrenous and ulcerated Azochloramid was applied locally sulfa drugs were administered and all other customary measures were taken to combat the infection. The gangrene and infection continued to spread involving all of the sole of the left foot and extending on to the dorsum of the foot. The oscillometric readings were zero at the ankle level and at the popliteal level. In split of daily dressings and careful attention to the local condition the gangrene spread involving the entire fore part of the foot.

I soon detected a peculiar odor reminiscent of bad cases of 'athlete's foot' and similar my cotte infection. This prompted the decision to apply a fungiculal agent. Accordingly, pure crystallites sodium propionate was sprinkled lightly over the gangrenous sloughing portions of the foot and axochloramid in triacetin was applied over this After a fow weeks there was a dramatic change in the appearance of the foot. The gangrens which had been spreading slowly established almost overnight a definite line of demarcation through the middle of the foot the peculiar odor disappeared and the edoma of the foot and leg subsided

Clinically it appeared that the acute necrotising process had been definitely checked and that the healing repearative stage had started. Simultaneously the patients signeral condition improved greatly pain became less aleep was now possible throughout most of the night and his appetite became prodigious. The astonishment of his immediate family at the sudden change in the clinical picture was notworthy. It was now comparatively cast to separate most of the sloughing tissues and healthy granulations appeared throughout the involved area.

At this stage treatment was changed to daily foot sooks of green suap and water followed by dusting with calcium propionate in a boric acid powder base. As I was unable to obtain an additional supply of pure sodium propionate, I requested the manufacturer of Sopronol (calcium propionate in a tale base) to supply me with the active ingredients of Sopronol in the bland, non-irritating boric acid powder base. After application of the powder, a dressing of boric acid ointment spread on gauze was applied to cover the entire ulcerated area. The procedure was repeated three times a week, and on May 15, 1946, eight months after the first application of sodium propionate, the stump of the foot was completely healed and the patient was able to get about, handicapped only by a partial contracture of the knee

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Case 2—E K., a woman aged 59, had had her right leg amputated two years previously for diabetic gangrene of the right foot. Two weeks before my first consultation on July 9, 1945, she noticed an infected "corn" on the small toe of the left foot. Wet dressings had been applied, resulting in spread of the infection with lymphangitis ascending above the ankle

The oscillometric reading at the left ankle was zero, indicating an advanced arteriosclerotic process. The blood sugar was 210, and 10 units of regular insulin twice a day were required to maintain the urine sugar free. At this time, treatment consisted of the local application of azochloramid in triacetin, bed rest, and control of the diabetes.

In spite of these measures, secondary gangrene of the toe set in, and notwithstanding careful daily dressings, the infection spread to adjacent toes and the foot, resulting in progressive secondary gangrene of all the toes and of the fore part of the foot. The clinical picture became alarming, since there was no response to the usual measures used in previous cases

On December 20, 1945, it was decided to apply fungicidal treatment in addition to the ordinary applications. At each dressing, after a foot soak with green soap and water, the involved areas were dusted lightly with calcium propionate in a boric acid base, and gauze, soaked in azochloramid in triacetin, was next applied.

As in the previous case, a dramatic change in the clinical picture was apparent within a few days. The gangrenous process became sharply demarcated, all signs of infection disappeared, and edema of the foot and leg were noticeably diminished. Simultaneously, the patient's general condition improved, and the insulin requirement became less. Sloughing gangrenous tissues were easily separated, and when healthy granulations appeared in various parts of the area, boric acid ointment was substituted for azochloramid, and the fungicidal powder was continued. In spite of the poor oscillometric reading at the ankle, healing was slow but progressive, and on March 15, 1947, the stump of the gangrenous

foot was completely healed, and the patient was able to get about, hindered only by the diabetic retinitis and glaucoma which had set in

Comment

Two cases of massive gangrene of the foot are described, each due to extensive arteriosclerosis obliterans, one with and one without diabetes mellitus. In each case the arterial circulation was gravely impaired, as indicated by an oscillometric reading of zero at each ankle. Although this type of case has been notoriously difficult to heal because of the bad circulation, it is noteworthy that in spite of this handicap, spontaneous demarcation of the gangrene and subsequent healing of the stumps, without resort to skin graft, was possible

In the treatment of these cases, practically no attention was paid to the arterial circulation in the extremities, while great importance was attached to the element of infection. The pyogenic infection was treated with azochloramid, while the my cotic infection was attacked with salts of propionic acid. Results, which had been unattainable with ordinary methods heretofore, were observed.

It is felt that the dramatic change in the clinical picture in each case, coincident with the use of fungicidal agents, is significant, particularly since similar events have transpired in a large series of less extensive cases of gangiene treated in the same way. Cultural studies are under way to observe the effect of the application of fungicidal agents upon gangrenous tissues. It is hoped that these experiences will focus attention upon the hitherto neglected aspect of infection in peripheral arterial gangrene.

151 East S3RD STREET

Acknowledgment With the cooperation of Mr Montell of the Mycoloid Laboratories a special preparation of the salt of propionic acid in a boric acid powder base was made avail able. A similar combination of the salts of undecylenic acid in a boric acid powder base was supplied by Dr Reiner of Wallace and Tiernan.

The boric acid powder is not irritating to open wounds and provides a suitable medium for the action of the fatty acid salt. It is promised that these compounds will be

available commercially in the near future

Recently through the courtest of Wyeth Inc a combination of propionic and caprylic acid salts has also been supplied

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FELLOWSHIP EXAMINATIONS FOR COLLEGE OF CHEST PHYSICIANS

The Board of Examiners of the American College of Chest Physicians has announced that the next oral and written examinations for Fellowship will be held at Chicago, June 17, 1948 Candidates for Fellowship in the College, who would like to take the evaminations, should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

PENICILLIN ADMINISTRATION VIA THE VAGINA

ROBERT I WALTER M.D. MORRIS A. GOLDBERGER M.D., and Louis S. LAPID, M.D. New York City

(From the Gynecologic Service of Mount Sinas Hospital)

IN A previous communication it was demon strated that penicillin calcium in cocoa butter suppositories is readily absorbed through the varinal mucosa and appears in the blood stream in therapeutic levels 1 This method of administration has obvious advantages it is painless can be carried out in the home and clinic and does not require the numetrations of nurse or physician

In this paper we wish to report five cases demonstrating the clinical application of this method of penicillin administration. All of the following cases were hospitalized in order to have accurate control of the medication and for the purpose of close observation of the course of the diseases studied. The penicillin was adminis tered in the form of vaginal suppositories each containing 100 000 units of penicillin calcium in a base of cocoa butter *

Case Reports

Case 1 - A 26-year-old gravida III para II was admitted September 9 1946 The relevant past history revealed an induced abortion five months prior to admission followed by a febrile course for ten days. The present illness had begun two days prior to admission with the onset of bi lateral pelvic pain and fever There were no gastrointestinal or urinary symptoms and the menstrual cycle was normal The physical examination re-vealed an acutely ill woman The temperature The physical examination rewas 103 6 F pulse 104 and respirations 24 The abdomen was diffusely tender with rebound tender ness and muscular spasm in both lower quadrants Pelvic examination revealed a normal vagma and cervix with marked tenderness in both tubes and Ovaries The oterus was normal in size and position and no pelvie masses were palpable

The laboratory findings were as follows sedimentation rate 17 mm in twenty four minutes hemoglobin 55 per cent 18 000 white blood cells Cer vical amear was negative for gonococci clinical diagnosis was acute bilateral salpingocophoritis with polvic peritonitis cause undeter mined

The patient received two suppositories of peni cillin calcium every two hours for 30 doses followed by two suppositories every four hours for four doses. The blood serum level of penicillin following the twenty-eighth dose of medication was 18 Oxford units per co. The total dosage was 6 800 000 Oxford units. Duration of the treatment was five days. The temperature fell to normal after forty

eight hours and abdominal signs of peritonitis cleared The final examination at the time of discharge on September 9 1940, revealed a normal pelvis with no adnexal masses

Case 2 -This patient was a 22-year-old nulli gravida who entered the hospital on July 20, 1946 with the chief complaints of pelvic pain, chills and fever of four days duration. The onset of pain coincided with the cossation of a normal menstrual period The patient was acutely ill The temperature was 102 8 F and the entire abdomen was tender with direct rebound tenderness in both lower quadrants. There was a moderate amount of cervical discharge. The exact size of the uterus could not be determined because of marked pelvic tenderness. Both tubes and ovaries were markedly tender but no masses could be outlined.

The laboratory findings were as follows sedimentation rate (Westergren method) 53 mm in eighteen minutes hemoglobin 70 per cent 11 500 white blood cells. Cervical amear was positive for gramnegative intracellular diplococci. The clinical diag nosis was acute specific cervicitis and bilateral salpingo-cophoritis.

The patient received two vaginal suppositories of penicillin every four hours for 18 doses followed by one vaginal suppository every four hours for four doses The total dosage was 4 200 000 Oxford units. The temperature fell by lysis to normal on the third day following admission On the second hospital day the abdomen was soft nontender and all signs of peritoneal irritation had disappeared Cervical smear studies at this time were negative for gonococci Pelvic examination four days after admission revealed normal palpatory fludings. The patient was discharged July 24 1946

Case 5 -A 26-year-old nulligravida was admitted to the hospital on July 21 1946 with chief complaints of lower abdominal pain, fever and sanguineous vaginal discharge of eight days duration Physical examination revealed a moderately ill woman in no obvious distress Temperature was 102 F The abdomen was soft and tender in the suprapubic area. Pelvic examination showed a profuse sanguinopurulent cervical discharge. The uterus was soft globular and tender The tubes and ovaries were neither tender nor onlarged.

The laboratory findings were as follows cervical smear positive for gonococci hemoglobin 80 per cent 6 700 white blood cells Wassermann nega tive 370 000 platelets

Ong penicillin suppository was administered every two hours for 17 doses. The total dosage was 1 700 000 Oxford units. The temperature fell by lysis to normal in three days and the cervical smear was negative for genococci at the end of twenty-four hours In addition to specific therapy the patient

^{*} Provided by Schenley Laboratories, Inc.

was transfused with 1,500 cc of whole blood The pelvic examination was negative at the time of discharge on August 8, 1946

Case 4—A 32-year-old gravida II, para II, was admitted on September 6, 1946, with the chief complaints of profuse vaginal discharge, dysuria, and mild pelvic pain of three days' duration. The patient admitted unprotected intercourse ten days prior to admission with a man known to be receiving treatment for gonorrhea. The patient did not appear ill. Pelvic examination revealed urethral and cervical discharge. There was slight tenderness in both adnexal regions on bimanual examination.

The laboratory findings were as follows smear and culture of cervix and urethra were positive for gonococci, hemoglobin 61 per cent, 9,500 white blood cells, Wassermann negative. The clinical diagnosis was acute specific urethritis, cervicitis, and salpingitis.

The patient received one vaginal suppository every four hours for 22 doses. The total dosage was 2,200,000 Oxford units. The vaginal discharge and urinary symptoms disappeared within twenty-four hours, and smears and culture of the cervix and ure-thra were negative in forty-eight hours. The patient was discharged on September 11, 1946.

Case 5—A 58-year-old gravida I, para I, was admitted to the hospital on August 26, 1946 The patient's chief complaints were dysuma, frequency, and fever In 1934, a right nephrectomy had been performed for chronic pyelonephrosis Past history revealed a sensitivity to sulfonamides

The patient appeared chronically ill Her temperature was 101 4 F, and there was slight tenderness in the suprapubic region and over the left kidney posteriorly The clinical diagnosis was acute cystitis and pyelitis Urine examination showed 2 plus albumin, occasional red blood cells, numerous clumped white blood cells, and Streptococcus viridans on culture Two vaginal suppositories were administered every three hours (with the omission of the 3 00 AM medication) for forty-eight hours for a total dosage of 2,800,000 units The urinary symptoms subsided, and the temperature fell to normal within twenty-four hours Urine examination was negative at this time She was discharged from the hospital on September 3, 1946

Comment

Although the number of cases presented is small, it seems to be fairly well demonstrated that the therapeutic results following the administration of calcium penicillin intravaginally parallel the results obtained with penicillin administered intramuscularly. A recent publication by Rock, Barber, and Bacon, indicates that 200,000 units of calcium penicillin in cocoa butter given intravaginally will yield the following blood serum levels "half-hour levels ranged from 0 312 to 1 250 units per cc with an average of 0 655 unit, after three hours from 0 to 0 156 with an average of 0 068 unit, at four hours from 0 to 0 312 unit with an average of 0 120

unit, at six hours from 0 to 0 156 with an average of 0 039 unit

"As the necessary concentration for streptococcus control is considered to be 0 039 unit and for staphylococcus from 0 078 to 0 1 unit, the critical amount was present—for an average of six hours"²

Lovelady, Randall, and Hosfeld demonstrated that in five cases there was no demonstrable penicillin in the blood serum three hours after the administration of 200,000 units of calcium penicillin intravaginally, whereas in six cases, following a similar dose, the blood serum level varied between 0 03 and 0 12 unit per cc ³

No local or systemic toxic symptoms were encountered in the cases reported here. We have used vaginal suppositories of penicillin in approximately 100 patients in the treatment of local genital pathology* and prophylactically in doses varying from 100,000 to 500,000 units every three hours. The most effective dosage has not yet been determined, and the highest doses were employed to determine the degree of tolerance.

In three instances patients complained of mild vaginal burning, and the drug was discontinued Usually the burning occurred after the first or second suppository. Objectively, no change in mucosa could be detected, and the symptoms ceased immediately. Further work will be necessary to determine the cause of this sensitivity.

The 100 cases mentioned above were treated for the following indications prophylactically in vaginal plastic surgery, cervical erosion, senile vaginitis, chronic endocervicitis, post-partum cervical lacerations associated with eversion of the cervix and endocervicitis, trichomonas vaginitis, and nonspecific vaginitis. The therapeutic results were encouraging, particularly in chronic endocervicitis and trichomonas vaginitis

Summary

- 1 Five patients with gonoccal and/or streptococcal infection were treated intravaginally with calcium penicillin suppositories
- 2 The therapeutic results paralleled those obtained with penicillin administered intramuscularly
- 3 The therapeutic efficiency of the intravaginal route of penicillin administration in the treatment of systemic diseases as compared with the intramuscular and oral methods, for example, was not accurately established. It would appear from known data that it is less efficient in terms of units required than the inter-

^{*} Dosage 100 000 units daily

mittent intransacular method and equally as efficient as the oral route

4 The use of the vagina as a depot or reservoir of pencillin in the treatment of systemic disease has obvious advantages in the case of administration, the ability to treat ambulatory patients and in the home, and in not requiring the ministrations of physician or nurse

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NEW CERFBRAL PALSY CENTER NOW OPEN TO PATIENTS

A cerebral palsy center combining diagnostic treatment and hospital services for patients with facilities for pursonnel training and for research on the disease is now in operation at LeRoy Genesee County as a joint project of the University of Rochester and the New York State Department of Health

The new center is housed in the former residence of Mr and Mra Ernest L Woodward who gave to the University their fifty-acre estate at L Roy and money with which to remodel the mansion on the site for use as a forty bed institution. The National Foundation for Infantik Paralysis granted the sum of \$292,000 for a five-year period of research to be

conducted by the University's departments of surgery, medicine pediatrics pharmacology physiol osy blochemistry and chemistry. The State appropriated \$150 000 for the fiscal year ending March 31 1018 to help finance the project

The financing of care for a patient is arranged prior to admission and it is expected that the majority will be admitted on orders of the county

children a courts.

Detailed information about the procedures and requirements for admission may be obtained by writing Dr. It. Plato Schwartz Strong Winnordal Hospital 200 Crittenden Boulevard Rochester New York or from the local district health officer

DOCTOR JONES SALS-

Funigation after cases of communicable disease—
I was just thinking about the time us health officers
used to spend on it and how important we figured
It was Formaldehyde and sulfur dioxide were the
two gases ordinarily used

If disease germs were around on the surface loose and unprotected, the gas probably killed em. But the formaldehy de didn't have any effect on flies and other insects. Oh, I s pose it made their eyes water some but it didn't kill em. The sulfur dioxide—that d kill the insects but it d tarnish metals and take the color out of things like curtains and unblostery.

I hadn't been health officer long before I had an experience that sort of opened my eyes. A boy with scarlet fover—we took him to the hospital I fumigated the house and when there weren t

any new cases by the end of the work, we felt safe Thirty days later, when the boy was well and all through peeling he went home. About five days later his sister came down with scarlet fover—The house was Oh but he still had the germs in his threat.

About that time we began waking up to the fact that it was people rather than inanimate things, that spread communicable diseases. They found out that fresh air, sunlight and scrubbing would do just as well and fumigation after such cases was discontinued.

Today—well disinfection still has its place but it is infected people mainly we work on They still fundgate but its vermin not disease germs they're after—I auf B Brooks MD Health Verr March 22 1918.

Case Reports

BASAL CELL CARCINOMA OF ANUS

JOSEPH M GROSS, MD, Brooklyn, New York (From the Proctology Service of the Beth-El Hospital)

BASAL cell carcinoma was the term applied by Krompecher in 1900 to describe the type of epithelioma in which all the cells stain deeply with hematovy lin, fail to cornify, and closely resemble the basal layer of normal epidermis ¹

Characteristically, a basal cell epithelioma shows only local invasive power—It does not invade the blood stream or lymphatic channels—It may destroy skin down to the superficial fascia where its penetration is usually halted—Spread will usually be superficial for a long period, and underlying tissue, muscle, or bone is invaded only late in the course of tumor growth

Chinically, basal cell epithelioma usually ulcerate early. With rare exceptions the ulcer is superficial, with a raised, irregular and everted edge, and presents a pathognomonic induration. For many months the indurated mass will remain freely movable before becoming densely adherent to the deeper tissues. Under the microscope, one sees clumps of cells growing down from the surface epithelium and lying free in the cutis. With hematoxy lin and cosin, the tumor masses stain more deeply than the overlying epithelium, and the edge of each mass is darker than its center. Mitotic figures are rarely seen in this slowly growing tumor.

Basal cell carcinoma of the anus is unusual Gabriel reports seeing only one such case ² Yeomans and Bacon cite none ^{2,4} Keyes says an occasional basal cell tumor is found ⁵ Guess reports a case which had been operated upon three times previously without being diagnosed ⁶

The usual type of anal cancer is squamous cell carcinoma. Estimates of its frequency range from 3 3 to 10 per cent 1-4 Bacon's collected statistics indicate that anal cancer, i.e., squamous cell, comprises 6 per cent of the malignancies of the anus, rectum, and sigmoid 4 The anterior quadrant of the anus is the most common site.

In diagnosing, this condition must be distinguished from the following possibilities—slough, chancre, condyloma, tuberculosis (verrucous or anal ulcer), chancroid, hemorrhoid, and nonspecific anal ulcer

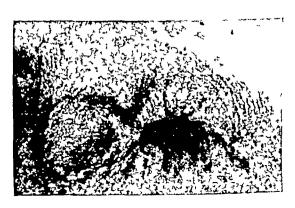
The ulcer resembled a slough seen occasionally after a peri-anal oil injection, but the duration, the bleeding, and the induration ruled that out. A chancre would not persist for a year. Condylomata rarely ulcerate and would have an indurated but necrotic base, a straight edge, and a strongly positive Wassermann. Verrucous tuberculosis may ulcerate

Such an ulcer has a sharply defined margin and a soft shallow base spotted with yellow tubercles. The discharge is thick, scanty, and foul smelling. A tuberculous anal ulcer has overhanging irregular edges without induration. Chancroid ulcers are usually multiple, the edges are not elevated, and there is no induration. An ulcer may result from the extrusion of the clot of an acute external thrombotic hemorrhoid. Here the history would be typical the ulcer would have ragged, overhanging edges, and fresh clots would be found in the crater. A nonspecific anal ulcer would not have a raised and everted border.

Differentiation between basal and squamous cell types is not merely academic, because the latter is highly malignant and metastasizes to lymph glands early. The edges of the former would appear more pearly and less raised. In an early case, wide excision is necessary either way. In more advanced instances, biopsy is necessary for an exact diagnosis. Both forms are sensitive to radiation, but metastases are resistant. For the late squamous type, radiation is preferable to surgery.

Case Report

The following case report is that of a 49-year-old milkman whose sole complaint was itching and painless bleeding from the anus for a year. Examination revealed an ulcer, 2 cm in diameter, with superficially eroded but clean crater and a border which was raised and everted. This mass extended anteriorly from the analyerge. Although definitely indurated, it was moveable and could be raised from the subcutaneous tissues (Fig. 1). The remainder of the examination was not remarkable. Inguinal glands were not indurated. The Wassermann was negative



Presented at a meeting of the New York Proctologic Society April 10 1947

The patient was admitted to the Betli-El Hospital on August 28 1946 with the chulcal diagnosis of ulcerated basal cell carcinoma of the anal margin On the following morning the tumor was excised widely to a depth of one inch and a diameter of three inches Cut portions of the subcutaneous sphincter ant and of the superficial transverse perineal muscles were approximated The subcutaneous fascia were sutured The skin defect was left open to granulate.

The pathology report read as follows Specimen consists of a round mass of skin with attached subcutaneous tissue, 4 by 3.5 by 2 cm, bearing in its center a rounded, centrally ulcerated mass 2 cm in diameter. The edges of the ulcer are heaped up and markedly firm. On section, opaque grayah-white tissue is seen to invade and replace the epidermal covering and to infiltrate into the superficial subcutaneous tissues. The tumor does not appear to involve the underlying muscle
have been completely excessed.' The diagnosis was basal cell carcinoma of the anus.

The wound has since healed satisfactorily the patient will remain under observation, no further therapy is deemed necessary.

Conclusion

While basal cell carcinoma of the anus is ran, the case is presented because tumors such as this may be mistaken readily for more benign anal lesions

285 New York Avenue

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* The patient was well and showed no evidence of recurrence in blanch 1948.

SCEPSIS SCIENTIFICA

In a recent address presented to the Leeds England University Medical Faculty by Geoffrey Jefferson this eminent physician stated that it is essential that we keep our emotions in con-trol in science although this may be difficult since they are permissible in so much else that occupies our thoughts colors our lives and at all times are ineradicable. The rules that we live by have been made by experience as curbs on unfettered emotional behaviors

The rules of science have a shorter history but are in the main of the same kind narrowed by a sharper focus to a different end We have seen that better knowledge of the brain gives us no hope for lenses that will correct automatically the astigma tism of our minds. Let us then live our lives ac cording to the rules of historical experience and in our scientific thinking let them be tempered but with our actions not paralyzed by scepticism.

A NEW TEACHING FILM AVAILABLE

The American College of Surgeons has announced the completion of a new teaching film, Anomalies of the Bile Ducts and Blood Vessels Strictures of the Common Duct,' which was shown at the 1947 Sectional Meetings and Clinical Congress of the American College of Surgeons and the Centennial Meeting of the American Medical Association This film is now available for loan or purchase and is the first in the series of teaching films being produced under the expanded motion picture program

The picture was directed by Warren II Cole

M D professor of surgery and head of the depart ment University of Illinois School of Medicine

with the cooperation of an advisory committee Production was made possible through a grant from the Johnson & Johnson Research Foundation.

The method of presentation used in this film is somewhat different from that commonly utilized Drawings with animation were employed inasmuch as operations for repair of stricture of the bile ducts are so numerous and also are so complicated that actual photography in an operating room was not considered practical

Inquiries may be directed to Lthicon Suture Laboratories Division of Johnson & Johnson New Brunswick New Jersey

ELECTRICAL ALTERNANS

HENRY H KALTER, M D, New York City, and Mortimer L Schwartz, M D, Irvington, New Jersev

(From Mount Sinai Hospital, New York City, and Irvington General Hospital, Irvington, New Jersey)

THE occurrence of electrical alternans is considered to be a rare phenomenon Hamburger, Katz, and Saphir reported that their first case, observed in March, 1933, constituted the only one they saw in a series of approximately 10,000 electrocardiograms covering a period of about thirteen years 1 We have reviewed 8,084 electrocardiograms taken in 6,059 different patients from July 29, 1941, to August 2, 1946, and have noted five instances of electrical alternans Our incidence is, therefore, one It is impossible to state how in 1,212 patients many of these 6,059 patients were suffering from heart disease, and, although the incidence of electrical alternans in cardiac patients cannot be determined. it is obviously greater than indicated above. Lack of familiarity with this abnormality is probably the reason for its infrequent detection

Electrical alternans is an abnormality of the electrocardiogram manifested by alternating variations in the amplitude or direction, or both, of the electrocardiographic waves and complexes, the rhythm of the complexes being regular. Electrical alternans of the QRS complexes is more frequent than alternation of the QRS complexes and T-waves. The phenomenon of electrical alternans may be evident in one or more leads, and occasionally it is seen in all leads. Since it is fairly transient, it seldom appears in more than one electrocardiogram out of several taken of the patient. In some instances, electrical alternans, a manifestation of cardiac alternans, is the only electrocardiographic evidence of heart disease.

Electrical alternans was discovered by Hering in 1909 in the course of animal experiments. Subsequently, other investigators produced electrical alternans experimentally and discussed its mechanism. The first instance reported in man was published by Lewis in 1910 in a case of paroxysmal auricular tachy cardia. Since then and up to the present writing, omitting cases of alternating atrioventricular block and alternating bundle branch block, we have found 41 clinical cases of electrical alternans reported in the literature.

Case Reports

Case 1—L S, a 27-year-old man, was admitted to the hospital on May 10, 1944 He complained of weakness and dyspnea and had a fever ranging from 102 to 104 F Three months prior to admission, an x-ray of the chest revealed markedly enlarged hilar lymph nodes On admission, the patient appeared acutely ill The temperature was 102 F, the respiratory rate was 28, the pulse rate was 120 and regular, and the blood pressure was noted as 120/80 The heart was enlarged to the right and left, heart sounds were distant, and a pericardial friction rub was heard. Physical signs of a pleural effusion were elicited at the left lung base posteriorly The liver was palpable four finger breadths below the right costal margin

Ninety cubic centimeters of serofibrinous pericar-

dial fluid were removed to sulfadiazine medication Moderate restriction of fluid intake and the administration of digitalis and mercurial diuretics did not influence the cardiac status of the patient Sixweeks after admission, a chest x-ray revealed that the enlarged hilar nodes had receded The patient was transferred to another hospital

The diagnosis was acute serofibrinous pericarditis with congestive heart failure of undetermined cause

Electrocardiographic tracings were taken on May 13, 16, 20, and 30 On May 16, 1944, there was sinus tachycardia, rate 125 P-waves were prominent in lead 2, P-R interval measured 0 16 second The R-wave in lead 4F varied from absent to ½ mm Electrical alternans of the QRS complexes and T-waves was shown in leads 3 and 4F (Fig 1)

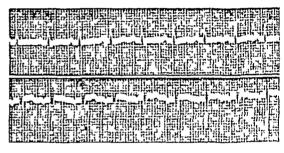


Fig 1 Electrical alternans of the QRS complexes and T-waves in leads 3 (top) and 4F (bottom) In lead 3 the alternation of the R-waves is very slight. The larger R-waves are followed by slightly inverted T-waves, and the smaller R-waves are followed by upright T-waves. In lead 4F the larger S-waves are followed by isoelectric T-waves, and the smaller S-waves are followed by upright T-waves.

Case 2—W O, a 57-year-old man, was admitted to the hospital on November 3, 1945 He complained of dyspnea and swelling of both ankles On admission, the patient appeared acutely ill The pulse rate was 100 with frequent extrasystoles, and the blood pressure was noted as 170/50 The respiratory rate was 24 The heart was enlarged to the left, a systolic and a diastolic murmur were best heard over the second interspace to the right of the sternum. Occasional rales were heard at both bases Examination of the extremities revealed 2 pluspitting edema of both ankles. The blood serology was positive

The patient improved on bed rest, restriction of fluids, digitalis, and mercurial diuretics

The diagnosis was luctic aortic insufficiency with marked hypertrophy of the left ventricle and congestive heart failure

Tracings were taken November 4, 7, and 29 On November 7, 1945, sinus rhythm was regular, rate 90 Previous auricular and ventricular extrasystoles were no longer present P-waves were notched in lead 1, prominent in lead 2, and inverted in lead 4F The P-R interval measured 0.18 second

Liectrical alternans of QRS complexes was shown in leads 2 and 4F (Fig. 2) the RS-T segment being depressed in all limb leads and elevated in lead 4F and the T waves being inverted in lead 1 and dipha sic in lead 2.

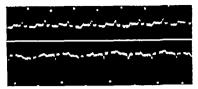


Fig. 2 Lectrical alternans of the QRS complexes in leads 2 (top) and 4F (bottom)

Case 3 — J. K. a 55-year-old man, was admitted to the hospital on July 29, 1942. He complained of dysprea on exertion occasional attacks of dysprea at night causing him to sit upright in bed mild productive cough and nocturnia. These symptoms had been present for four months prior to hospital ization. On admission the patient is pulse rate was 72 and regular the blood pressure was 120/78, and the respiratory rate was 24. Examination of the lungs revealed diminished breath sounds with occasional wheezing in both lung fields. Physical examination of the heart was essentially negative, but x-ray of the chest revealed slight enlargement of the heart to the right. The liver was palpable two finger breatishs below the right costal margin. The circulation time with other was 11 seconds and with decholin was 18 seconds. The sodimentation rate white blood cell count and differential count were normal. Examinations of urine and blood serology were negative.

The patient had been receiving digitalis prior to admiration He improved on bed rest and continua

tion of digitalis medication.

The diagnosis was chronic bronchitis and emphy some with eccondary enlargement of the right ventricle and right heart failure.

Electrocardiograms taken on April 21 1942, showed regular ainus rhythm rate 72. Electrical alternans of QRS complexes was shown in lead 4F (Fig. 3) Otherwise the tracing was normal



Fig. 3 — Flectrical alternans of the QRD complexes in lead 4F

The patient died on September 24 1942 during a second admission of an acute illness unrelated to the above described sp mptomatology Postmortem examination revealed that the heart weighed 325 Gm. coronary arteries were patent. Right venticular musculature was firm reddish-brown in color, and measured 16 mm. In thickness approximately three times normal.

Case 4.—J K a 33-year-old man presented a history of attacks of paroxysmal achycardia. Physical examination on admission was negative except for a rapid heart rate. An emergency elementalization was ordered because of this market tachycardia. However the rapid rate substited

shortly before the electrocardiogram was taken. The diagnosis was paroxysmal tachycardia.

The patient was discharged as improved.

An electrocardiogram was taken November 21 the trace varying between 90 and 95 Electrical alternans of QRS complexes was shown in lead 4F (Tig. 4) Other wise the tracing was normal for a slender individual with a vertically placed heart

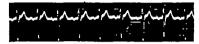


Fig. 4 Fleetrical alternans of the QRS complexes in lead 4F

Case 5 *—E. B a 03-year-old woman was admitted to the heepital on June 6, 1946. She gave a history of provious episodes of heart failure and she complained now of shortness of breath productive cough and pain in the left chest. The patient had a fover ranging from 102 to 103 F On admission, she appeared acutely Ill The temperature was 102 I, pulso rate was 100 and the blood pressure was 102 for the respiratory rate was 35 Examination revealed dulinoss over the left has posteriorly and resonant rates. The heart was enlarged to the left, the liver was three fingers below the right costan margin and the extremities showed some anklo edema. An x ray of the chest showed infiltration in the left lower lobe,

The patient was given oxygen sulfadiazine and pendellin. Her temperature returned to normal on the third day. Because of the cardiac failure the patient was placed on a low salt diet and received digitalis and mercupurin. The patient improved and left the hospital on July 11 1916

The diagnosis was pneumonia left lower lobe, and arterloselerotic heart disease with heart failure.

Electrocardiograms, taken on July 10 1046 show regular sinus rhythm rate 72. There was left axis deviation The P R interval measured 0.24 QRS complexes were slurred and widened and measured 0.12 second. R4 varied from absent to 1 mm Electrical alternans was present in lead CL4 (Fig. 5) but was absent in chest lead CL5. RST segments were depressed in leads 1 2 and CL5 and wvro elevated in lead 3. The T waves were inverted in lead 1 and CL5 and were depleased and CL5 and were depleased and CL5 and were depleased in lead 1 and CL5 and were depleased for lead 1 and CL5 and were diphasic in leads 2 and CL5.



Fig. 5 Electrical alternans of QRS complexes in lead CL4

Discussion

In recent years the majority of investigators have concluded that the various phenomena of cardiae alternans are produced by the same underlying nechanism. Kisch believes that the cause of car

Dr O J Beyer of Irvi gton, New Jersey has given u

diac alternans, whether electrical or mechanical, is a disturbance of the bioenergetic behavior of the myocardium 9 Katz states that the factor underlying all forms of cardiac alternans is a marked prolongation of the refractory phase of some part of the heart 31 Following a previous activation, an impulse finds some regions of the myocardium still Consequently, the response in every refractory alternate beat will be mechanically or electrocardiographically abnormal

Including the five cases presented in this paper, there are 46 instances of electrical alternans recorded Nine cases showed electrical in the literature alternation during attacks of supraventricular phroxysmal tachycardia, while one case reported in this paper is of additional interest because it showed electrical alternans immediately after such an attack. These cases will not be discussed further because clectrical alternans is not of prognostic significance under such circumstances

In the remaining 36 cases, alternation of the QRS complex alone occurred in 29 patients, and alternation of the QRS complexes and T-waves appeared in seven patients

Association of electrical alternans and pulsus alternans has been reported in only six cases by Lewis. Brody and Rossman, Nadrai, Kalter and Grishman, and Levine 15 22 26 20 20 In the first instance, the patient exhibited a paroxysmal auricular tachy-The electrical alternans in these six cases was of the QRS type in four instances and of the QRST type in only two instances The rarity of this association may be attributed to the fact that simultaneous tracings of pulse and electrocardiogram are not recorded routinely Since the phenomenon of cardiac alternans is transient, the association of electrical and mechanical alternans often is over-However, it should be noted that a patient may exhibit electrical alternans without pulsus alternans on one occasion and pulsus alternans without electrical alternans during another examination 15 29

The absence of electrical alternans in the routine electrocardiogram does not exclude the presence of the electrical phenomenon Additional leads might This is demonstrated have revealed its presence in case 5 in which the electrical alternans is absent in the limb leads and CL5 but is present in CL4

The mortality among the 36 patients was 22 cases The clinical course and prognosis in or 61 per cent the remaining 14 cases are not always completely described Some patients have shown remarkable improvement while under treatment and observa-This should caution us against regarding election trical alternans as of ominous significance in every The mortality in the QRS group is 18 deaths case out of 29 cases, or 61 per cent The death incidence in the QRST group is four fatalities out of seven patients, or 57 per cent Thirteen postmortem evaminations are reported in the literature 17 21 23 24 26 28 29

There is no reason to associate the phenomenon of electrical alternans with any particular cardiac dis-Chronic cardiovalvular disease and pericarditis were more common postmortem diagnoses than was coronary artery disease, the latter having been present in only five cases among the 13 patients which came to necropsy All types of heart disease were diagnosed clinically in the remaining 22 cases Heart failure was a very frequent occurrence

The age varied from nine months to seventy-five years, the majority of the patients being more than forty years old

Summary

- Five cases of electrical alternans are reported
- 2 The incidence of electrical alternans is much higher than has been reported in the literature, lack of familiarity with this phenomenon being the reason for its infrequent detection
- Marked improvement may occur in patients exhibiting electrical alternans, although the latter is usually a poor prognostic sign when it is not associated with paroxysmal supraventricular tachycardia
- Electrical alternans may appear in cardiac disease regardless of etiology

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TRANSTHORACIC GASTRECTOMY, SPLENECTOMY, AND SUBTOTAL PAN CREATECTOMY FOR RECURRENT CARCINOMA OF THE STOMACH

JACOB L OLENIK, M D , New York City (From the Bronx Hospital)

THE gloom attending the reports of results of the treatment of cancer of the stomach still prevails but recently now hope has been inspired by an in creased interest shown by surgeons in radical extirpation Publicity and education of the patient and the family doctor have brought more and earlier cases to the attention of the surgeon. Thus, the per centage of operable cases is increasing as is the number of cases found to be resectable by laparotomy

Lastly improved preoperative preparation and postoperative care have joined with better operative technic and nower methods of anosthesia in making radical surgery of the stomach less hazardous Now that the transthoracic approach to the upper abdomen has given us greater and more direct access to the stomach and adjacent involved organs even more radical procedures have become feasible

Although recurrent carelnomas of other portions of the gastrointestinal tract have frequently been oper ated upon successfully and reported a search of the llterature did not reveal a recurrent carcinoma of the For this reason and because stomach thus treated of general interest, the following case history is presented.

Case Report

Course -On March 11, 1046 a fifty two year old white man, a commercial printer was admitted to the Bronx Hospital with a one-year history of recur rent episodes of epigastric discomfort and pain late, these incidents had become more frequent and more persistent. The most recent attack had lasted five weeks. The pains were described as severe heartburn at any time day or night, without rela-tion to time or content of meals. Bicarbonate of sodia gave slight relief temporarily but ingestion of food had no effect upon the symptoms. At no time had he experienced nausea, nor had he vomited dur ing an attack. He had never been jaundiced, nor had he ever noticed anything unusual in the color or contents of his urine or stool There had been a weight lose of ten pounds in the past three months This was attributed by the patient to worry and, recently to anorexia. A gastrointestinal x ray series done elsewhere was negative but x rays of the biliary tract disclosed a faintly visualized gallbladder

containing many calculi.

Aside from the fact that his father had died of cancer (organ was not known by the patient), we could learn nothing of consequence concerning his family or past history Physical examination revealed an alert white man who showed evidence of recent weight loss. His blood pressure was 140/00 The head, neck and extremities were negative. Heart and lungs were normal The abdomen was scaph old in type. No masses were felt or points of tenderness found. The liver edge could not be felt and the spleen was not palpable.

I am indebted to Dr Joseph Felsen, director of labora-tories and research at the Bronz Hospital for the photo-micrographs presented.

On admission to the hospital his blood showed homoglobin 14.5 Gm red blood cells were 5,500 000 and white blood cells were 8,200 of which 70 per cent were neutrophils. The blood was type B

Landsteiner The urine was normal

On March 12 the patient was operated upon The following is excerpted from the operative report "Under spinal and pentothal sodium anosthesia, the abdomen was entered through a muscle-splitting upper right rectus incision. It was found that there were many adhesions present in the region of the gallbladder These were separated and the exposed gallbladder was found to be thick walled and contained numerous stones. The liver surface was smooth and contained no palpable nodules. The appendix was normal. Both kidneys were normal in size. The large and small bowel were free of any palpable tumors. On the posterior wall of the stomach high up there could be felt a mass. The lesser sac was opened through the gastrocolic ligament to get a better exposure of the posterior surface of the stomach. It was seen then that an ulcerating neoplastic lesion of the posterior gastric wall well below the cardia was present. Several large nodes were palpated in the gastrohepatic ligament

It was decided to do a subtotal gastrectomy division of the duodenum and the closure of the The duodenal stump presented no difficulty stomach with its attached omentum was resected without the use of clamps in order to get as high a division as possible. After the stomach had been transected it was thought prudent to remove more of the posterior wall, although we were apparently above the tumor The posterior wall, therefore was excised just below the esophagus The edges of the anterior wall were sewed together posteriorly and the upper end of the tube thus formed anchored to the remaining cuff of the posterior wall with several interrupted sutures. Because of its location, this procedure was difficult and we could not be certain as to the efficacy of this row of sutures. The proximal jejunum about thirteen inches from the ligament of Treits was then brought around the colon opened and anastomosed to the distal opening in the recently made stomach tube The operation was completed in the usual manner No drainage was instiinted.

During this procedure, both plasma and whole blood, in addition to continuous intravenous administration of 5 per cont glucose in saline were given The report made by the pathologic laboratory

follows

Gross Pathology —The specimen is a resected por tion of stomach, 18 cm. in length. The scrosal sur-face is pink and smooth except in one area on the lesser curvature where it appears to be puckered This area is near one extremity of the resected por tion of stomach The mucesal surface presents a reddish cauliflower like, heaped-up friable neo-plastic mass measuring 7 by 6 cm in size. The edges of the mass are serpiginous in character, and the surrounding mucosa is hemorrhagic. The wall of the stomach in this area in markedly indurated On examination no lymph nodes are palpable or visible

Microscopic Diagnosis -Section of the stomach

tumor at the junction with normal mucosa reveals a deeply penetrating adenocarcinoma. The tumor reveals considerable varieties in its histologic appearance. In some areas, well-defined varying-sized glands are seen. In other areas, there is a tendency toward papillary growth. In still other areas, large dilated and cystic glands are seen. The lumina are filled with mucinous secretion, and little or no epithelium is present. Numerous focal calcific deposits are present. In areas the stroma is infiltrated with polymorphonuclear leukocytes and round cells.

Diagnosis —Gelatinous adenocarcinoma of stomach, grade II (Fig. 1)



Fig. 1 Photomicrograph showing the microscopic anatomy of the carcinoma found in the posterior gastric wall

Postoperative—The patient with stood the operation well and was in good condition on his return to his room. Intravenous glucose, saline, and amino acid feedings were started. Vitamin and penicillin therapy, was instituted.

apy was instituted

The postoperative course was satisfactory until March 16 when bronchopneumonia complicated the convalescence This cleared, and the patient was well by March 19 On that day he was given his first peroral fluids The wound healed rapidly, and the patient was discharged from the hospital on March 30

The patient was kept under observation for seven months At the end of four months he had gained twenty-five pounds and was in excellent health, working at his trade happily

On October 1, 1946, the patient complained of epigastric pain. A gastrointestinal series revealed a recurrence of the carcinoma of the stomach with infiltration around the stoma of the anastomosis (Fig. 2)

The patient returned to the hospital October 15 Physical examination on the day of admission was as follows—there was no pallor, he seemed well nourished, the incisional scar of the previous operation



Fig 2 X-ray showing recurrence of carcinoma, with infiltration around the stoma of the anastomosis

was well healed, no masses were palpable nor were any points of tenderness found. Blood pressure was 138/90. Urine examination was negative, his hemoglobin was 98 per cent (14.5 Gm.). He had 4,760,000 red blood cells and 10,000 leukocytes, of which 54 per cent were polymorphonuclear. The nonprotein nitrogen urea and creatinine were normal. The total protein and albumin-globulin ratio were normal.

For the next six days he was given a high protein, high carbohy drate, high vitamin diet. On the fifth and sixth days, sulfadiazine therapy was instituted

On the seventh day, October 21, under intratracheal positive pressure cyclopropane and ether anesthesia, exploration of the abdomen through the transthoracic route verified the x-ray findings was interesting to note how nature had in this short time re-formed a new symmetric stomach pouch from the distorted tube-like stomach previously reconstructed No scars, indicating the suture lines of the anastomosis, could be detected Scattered areas of tumor tissue infiltrated not only the stoma of the previous gastrojejunostomy but also the new posterior wall of the stomach The latter was adherent to the tail and distal portion of the body of the pancreas where several nodules could be felt. There pancreas where several nodules could be felt were no apparent liver metastases, nor could seeding to the peritoneal surfaces be found The decision The spleen was made to do a total gastrectomy was removed first because it persisted in interfering with manipulations and could not be pushed aside After the many adhesions were separated, the entire stomach and portion of jejunum constituting the Because of the previous anastomosis were resected nodules found therein, the tail and greater portion of the body of the panereas were resected penunum was reconstructed, and at a point distal to this reconstruction it was anastomosed to the

esophagus in the chest just above the diaphragm Cutting the blood vessels in the mesentary of the portion of the journum to be used as the loop for the anastomosis. as suggested by Sweet, facilitated the anastomosis. The latter was then sewed around the jejunal loop so that the anastomosis was com-pletely within the chest. The abdomon was not pletely within the chest. The abdomen was not drained but a tube for underwater drainage was left in the chest cavity which was then closed tightly No sulfa drug or penicillin was sprinkled in the chest

During the operation the patient received several transfusions of whole blood and two units of plasma. He was returned to his room in fair condition and was placed in an oxygen tent During the next two days his condition was good. The underwater drain During the next two age of his left chest was suspended On October 23 the second postoperative day a routine x ray of the theat showed some clouding over the left lung due to pleural reaction with only a small amount of fluid

lòrmation.

On October 25 four days postoperatively there was some distention of the abdomen For the next three days the distention increased. An x ray of the abdomen taken on October 28 showed distention of the large and small bowel with gas. Barium enema was attempted. Good filling was obtained as far as the midsigmoid. The impression of our reentgenelogist, Dr Snow was that we were dealing with an adynamic ileus. In spite of prostigmine and xyphonage irrigation of the rectum the distention continued to get wome. At this time decompression with a Lovine tube was not attempted because of the possible danger to the esophageal anas-Reconsulting the x-rays, the x ray department felt that they could not positively rule out a mechanical obstruction, so on October 29, under local anesthesia a cecostomy was done. For the next forty-eight hours there was no improvement in the amount of distention but on November 1, the patient began to pass a great deal of gas the disten-tion rapidly diminished and within a few days had completely disappeared. Blood translusions and plasma were utilized frequently to reinforce the intravenous feedings of amino acids vitamins, and glucose in saline. Oral feeding started November I and was increased slowly By November 5 the the patient was taking a soft diet and by November 11 he was able to swallow easily and utilise the regular house diet. The eccostomy functioned well after peristalsis reappeared and fecal matter was passed por rectus as well

From then on, his course was uneventful and he was discharged from the hospital on November 17

with the eccestomy still draining.

The following is the report from the pathologic

laborator

Gross Pathology - Specimen consists of two por tions of rib the larger measuring 9 cm. in length. These show no gross pathology Also received is a spicen measuring 0.5 by 8 cm. in size. The capalle of the spicen is smooth and purplish-red in color On section, the spicen is firm in consistency grayish red in color, and apparently shows no gross pa Also received is a resected portion of atomach measuring 14 by 10 cm. in size which was sec tioned before arrival in the laboratory The mucosal surface of the stomach at one portion of the resected specimen shows an ulcerated neoplasm measuring 3.5 by 2 cm. in size The edges of the ulcer are thickened and raised and rolled. They slope sharply Adjacent to this tumor there are to a reddish base ecen several elevated, pinkish yellow densely hard nodules of tumor tissue. The wall of the stomach in this area measures 5 mm, in thickness. The across

in the same area is puckered and scarred in appearance The remainder of the mucosa of the stomach shows s veral hemorrhagic ulcerated areas. The remainder of the seroes of the stomach shows no gross In one area of the scrosa there is what pathology appears to be a questionable lymph node measuring 0.5 cm in size. This is taken for section. Received separately is a portion of small intestine measuring 15 by 2.5 cm in size. The serosal surface The wall of the bowel is 3 mm. is pink and smooth in thickness The mucosa shows the normal jejunal folds and is pink and smooth. Received separately is a portion of adipose tissue containing what appears to be the body of the puncreas The portion of pancreas measures 8 by 2 cm. in size and on section the pancreas appears to be of a brighter yellow color than usually is seen and is moderately firm in consistency In some areas there is evidence of hemorrhage In the peripanereatic fat there is noted a lymph node 1 cm, in size

Microscopic Diagnosis —Several sections of stomach wall reveal evidence of ulceration, congestion and cellular infiltration but no evidence of malig One section apparently taken from the gastric neoplasm reveals a well differentiated adenocarcinoma imbedded in a desmoplastic stroma. Several sections of pancreas reveal normal tissue. The islands of Langhans are prominent and numer ous. In one area a few dilated ducts are present.

Section of the spleen reveals no pathology
Diagnosis —Gastrio carelnoma, grade I or II



Photomicrograph showing the microscopic anatomy of the recurrent lesion. Fra 3

Supplementary Report -Further sections of the stomach show a sone of transition between normal mucosa and an adenocarcinoma which is seen ax tending into the muscularis. Considerable infiltra tion with round and plasma cells is noted

Follow-up Examination. I have seen the patient frequently since his operation The eccestomy has

closed completely, and food is swallowed easily Repeated blood examinations showed a constant improvement of the anemia with which he left the His glucose tolerance tests gave normal results and, for the time being at least, he seems to be well

Summary

A case of carcinoma of the stomach is presented

in which subtotal resection, resulting in seven months of excellent health for the patient, was followed by local recurrence A transthoracic resection of the remaining portion of the stomach with a supradiaphragmatic esophagojejunostomy was performed successfully

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SUPPRESSIVE EFFECT OF PENICILLIN

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(From Physicians Hospital)

THE bacteriostatic and bacteriolytic properties of penicillin are well known Also, there have been recorded many warnings concerning the production of penicillin resistant strains of bacteria. In mixed infections, it has been shown that if those organisms which are sensitive to penicillin are controlled, the natural body mechanism for fighting infection can overcome those organisms which are undisturbed by the action of the penicillin. Such is the rationale of the Crile treatment for appendiceal abscess

The suppressive effect of penicillin on infection is shown in the various ways mentioned above ports, however, on how long such suppression can continue have not been made The following case is instructive, in that "control without cure" continued over a period of approximately three years. The most important feature lies in the fact that at no time over the three-year period was the patient well or able to carry out his work.

Case Report

L M, a man aged 22, was first seen on March 17, 1947 He complained of pain at the site of incision of a previous appendectomy, pain in the right lower quadrant on walking. This pain was relieved if the patient pressed upon his right lower quadrant with his hands These symptoms had recurred many times and were accompanied by a mild diarrhea

On April 14, 1944, while in the armed services, he was operated upon for a ruptured appendix. At operation the appendix was removed and the peritoneal cavity drained. He had a very stormy postoperative course and received injections of penicillin every four hours for a period of four-teen months. The amount of penicillin is unknown.

He was still a hospital patient in October, 1945 (eighteen months postoperative), but was considered well enough at that time to go home on sick leave He took a train for New York City, but just before the train arrived at Pennsylvania Station his wound burst open, and a large quantity of pus ran out He discontinued his journey and immediately returned to his camp and hospital As soon as he returned an operative procedure was carried out for "drainage" Penicillin was again given

In December, 1945, a third operative procedure was carried out, and, following x-ray of a sinus tract, the wound healed The patient was then discharged from the hospital and from the service on a Certificate of Disability Discharge

From the time of discharge, December, 1945, until first seen in March, 1947, he had never felt well, was unable to do any work, and had numerous "bouts" of right-sided pain and diarrhea

On April 17, 1947, he suffered another acute attack of right lower quadrant pain and diarrhea.

He was immediately sent to the hospital

Physical Examination —The patient was a welldeveloped, fairly well-nourished man who appeared to be acutely ill and in pain. He lay with the right knee drawn up and stated that when he straightened it, he had severe pain in the right side of the abdomen. His face was flushed, the temperature was 103 5 F, and pulse 106

The heart was normal in size, shape, and position Heart rate was 106 No murmurs were heard The

patient's blood pressure was 120/80

Respiration was normal, and the lung fields were clear throughout Breath sounds were broncho-

vesicular throughout

There was marked spasm of the muscles of the right side producing a "board-like" abdomen, and there was extreme tenderness over the scars of previous operations in the right lower quadrant and There was no rebound or costovertebral tenderness Pressure on the left side of the abdomen did not increase the pain on the right side No masses or tenderness could be felt in either side of the pelvis on rectal examination. The prostate was normal in size and consistency

The urinalysis was negative, and a blood count gave the following results 4,800,000 red blood cells, 87 per cent hemoglobin, 17,500 white blood cells, 87 per cent polymorphonuclears (40 nonsegmented, 47 segmented cells), 12 per cent lymphocytes, 1 per cent

monocytes

Intraperatoneal abscess, residual of previously ruptured appendix, was the diagnosis made

Treatment —In accordance with the recommendations of Crile, the patient was given 100,000 units of penicillin every two hours for three days and then every four hours for three days. At the end of the first forty-eight hours, all his symptoms had disappeared, the abdomen was soft, the temperature pulse, respirations, and blood count had all returned to normal.

Exploration of the abdomen was carried out on the sixth hospital day, April 23, 1947 At operation there was no increase in intraperitoneal fluid and no The cecum and ileum were mobilized from the lateral abdominal wall with great difficulty due to firm fibrous adhesions A fistulous opening was found at the site of the appendiceal atump the edges of which were thickened by scar tissue. This portion of the head of the cocum was excised, and the

opening closed and reinverted The postoperative course was uneventful and the

patient was discharged on May 3 1947 On May 16, 1947 when the patient arose in the morning the transverse incision at the superior end of the original McBurney incision burst open and a large amount of thin, pale gray watery material containing fibrin flakes was discharged. There was some slight right lower quadrant pain felt mostly in the groin at this time. The patient was returned to homital

Immediately upon admission cultures and smears were taken from the fistulous tract. These showed the presence of pus necrotic tissue and Escherichia coli.

Since this sinus might be connected with the urinary tract, the patient was given methy lone blue tablets by mouth, but none of the dye appeared in the drainage.

Intravenous pyelogram showed normal kidney

pelves and ureters

The sinus tract was injected with opaque medium, and x ravs were taken This showed the presence of a large cavity which was believed to be retroperi toneal. Feathers looking extensions of the opaque medium ran upwards as high as the disphragm and downward into the pelvis. The spine was noted to be concaved to the right and there was an ab-

sence of the normal peoas shadow on the right Believing the condition to be an enormous retroperitoneal abscess extending from disphragm to pelvis and bothing all the retroperitoneal structures including the right kidney Dr H. L Schlesinger prologist was called into consultation and, with his assistance an operation was performed on May

22, 1047

At operation the annua tract was found to open into the main abecess cavity in the retroperitoneal space. The cavity was followed toward the flank and downward to the pelvis so that the incision extended from the iliac crest to the twelfth rib A rubber tube drain was run from the twelfth rib upward and over the under surface of the diaphragm. A second rubber tube drain was placed through the right inguinal region into the pelvis. The main cavity was found to be covered by a shaggy necrotic exudate. As much of this as possible was removed by a curet. The main cavity was then packed with approximately five yards of standard 2-inch vaginal packing gause soaked in asochloramid in triacetin The wound was approximated as much as possible.

For the first three days the postoperative course was stormy. In four days however the temperature was normal, and the patient was not suffering much pain. On May 28, 1047 removal of the pack ing was begun and each day the tube drains were irrighted with anochloramid solution The last of the packing was removed on June 2 1947 and a large tube was inserted in this opening for irrigating

purposes

Large amounts of discharge were obtained at st but decreased daily On June 10 1047 all first but decreased daily drains had been removed drainage had become alight, and the patient was up and about, and in his own words iccling better than I have in three years. He was discharged from the hospital June 12 1947

At his last examination on July 3 1947 all wounds were firmly healed, and he had gone from 140 pounds (at time of hospital admission) to 167 pounds in weight. He was working on a farm, feeling fine had regained his vigor, and had no pain of any kind

Comment

It was very puszling at the time of the first opera tion to find a definite fecal fistula without any posket into which there was drainage. It now seems cortain that when the cocum was freed the fistulous tract was clamped and tied at the point where the communication passed through the parietal peritoneum leading into the abscess cavity Thus the opening into the cecum was found but the pus from the abscoss cavity did not drain back, and therefore the cavity in the retroperitoneal space was not discovered

It seems almost impossible to believe that the retroperitoneal abscess was present and undiscovered from April 1944 to May 1947 yet this must be true. The sequence of events can only be explained if they are based on this assumption. The

explanation then, is as follows

In April 1944 following the original operation a fecal fistula became established between the head of the cecum and the retroperitoneal space. The course following this operation was at first stormy but then settled down to a chronic state months this service man received penicillin which suppressed but did not overcome the infection. That recovery did not follow the operation promptly is proven by the fact that he was kept in a military hospital for a period of eighteen months from April 1944 until October, 1945 when he was allowed his first sick leave

When the wound burst on the train, the presence of the abecess was definitely proved. Following his operations in October 1945 and December 1945 he again received long courses of penicillin therapy again with suppressive results.

In April 1947 on doses of 100 000 units of penicil lin every two hours the disappearance of symptoms and signs was most dramatic. At this time suppres-

sion-not cure-was again the result,

Cultures from the sinus in May, 1947 showing E. coli point to the probability of the previous connection with the head of the occum. The penicillin controlled the secondary infection but did not affect the E. coli The natural body mechanisms were able to control the effects of the E. coli in the tissue but could not overcome them. Thus the process continued over a period of three years.

Summary

- A case is reported which demonstrates the suppressive effect which pericillin may produce in some instances.
- 2. Penicillin therapy must never be relied upon to replace good surgery

71 BRINKERHOFF STREET

CONFERENCES ON THERAPY

DEPARTMENTS OF PHARMACOLOGY AND MEDICINE, CORNELL UNIVERSITY MEDICAL COLLEGE,
AND THE NEW YORK HOSPITAL

THESE are stenographic reports of conferences by the members of the Departments of Pharmacology and of Medicine of Cornell University Medical College and New York Hospital, with collaboration of other departments and institutions. The questions and discussions involve participation by members of the staff of the college and hospital, students, and visitors. A selected group of these conferences is published in an annual volume, Cornell Conferences on Therapy, by the Macmillan Company

Treatment of Diabetic Emergencies

DR. McKeen Cattell The subject of our conference today is the treatment of diabetic emergencies Dr Tolstoi will open the discussion

DR EDWARD TOLSTOI Too much insulin and too little insulin are the chief causes of medical emergencies in the diabetic patient. The overdosage and the insufficient dosage may be absolute or relative. Too much insulin leads to hypoglycemia, too little to keto-acidosis.

Absolute overdosage of insulin denotes the actual administration of more insulin than is necessary This situation is observed most commonly during the initial phases of the treatment of diabetes Some physicians are eager to clear the patient's urine of sugar and consequently either prescribe progressively larger doses of insulin at diminishing intervals or reduce the food While such a procedure may clear the urine of sugar, symptoms of hypoglycemia may Some of the patients so treated also develop may be restless at night and complain of headache on arising, or have a feeling of nervousness, weakness, and possibly vertigo These are symptoms of slight insulin overdosage overdosage may also result from a misunderstanding regarding the measurement of the To avoid this, it is wise to use a proper insulin syringe, one calibrated to correspond to the unitage of the insulin used A change from the 40-unit strength insulin to the 80-unit insulin is often confusing for the patient, particularly so, if the old 40-unit syringe is used If all details are not carefully explained and demonstrated, he may take double the prescribed quantity and, as a consequence, experience an insulin reaction

The treatment of the patient with slight insulin reaction is simple. A patient receiving protamine zinc insulin or a mixture of the protamine and the regular insulin, who, on arising, has a headache, is inattentive, or reveals other abnormal behavior, or who just does not feel himself, although he has no tangible complaints, and

who, in addition, finds his urine to be sugar-free, is probably having an insulin reaction He should take some orange juice at once and follow it with his usual breakfast. The disappearance of symptoms in these cases is not so dramatic as it is in those due to regular insulin I have observed the persistence of symptoms for one or more hours After the symptoms have subsided, the patient may feel a bit fatigued, but, as a rule, he can attend to his duties As an added safety measure, some food between breakfast and lunch is advisable The other step is obvious Reduce the insulin dosage Do not aim at sugar-free urine in the patient treated with protamine zinc A 1 or 2 plus morning glycosuria is acceptable even by the most conservative observers The specific instructions to the patient for the prevention and treatment of such insulin reactions are

- 1 Take 200 cc of orange juice at once
- 2 Follow by the usual breakfast which may include additional fruit juice
- 3 Take a glass of milk and three crackers two hours after breakfast

In addition, the physician should observe the following rules

- 1 Be certain that the patient understands how to measure the dose of insulin
- 2 Reduce the insulin dosage by five units every three days until there is asymptomatic morning glycosuria, the alternative being to increase carbohydrate in the diet
- 3 Be sure that the patient takes a glass of milk and three crackers at bed time

Relative insulin overdosage may assume different forms, but if one is aware of it as a possibility, its recognition is not difficult. Unusual activity is a predisposing cause. A gastrointestinal upset, especially with vomiting, is another. Let me relate some cases. A young woman who follows the daily routine of a university student, whose diabetes is well controlled with 30 units of insulin, and whose diet is gen-

erous is invited to a weekend party. During the day there are ice sports with much skating, during the evening considerable dancing. She takes a substantial dinner, but omits the crackers and milk at bed time During the night, she is aroused by her roommate who hears her breathing quite heavily. The patient is perspiring profusely and is somewhat confused. In this case, however, she has sufficient presence of mind to ask for orange juice This is taken and is fol lowed by chocolate, milk, and bread symptoms abate, and after some three hours of discomfort, she falls asleep. On awakening, her morning specimen does not contain any sugar in spite of all the carbohydrate she consumed during the night. This is a classic example of relative insulin overdosage created by unaccustomed activity Fortunately, in this case the diabetic knew what to do was sufficiently conscious, and could retain food which is the very best antidote for an insulin reaction. In similar situations, give readily available carbohydrate such as orange juice and other sweets at once After fifteen to thirty minutes, follow this with milk bread or crackers This will furnish not only additional but also a more alowly absorbed carbohydrate as a substrate for the insulin.

Here is another example of relative insulin overdoeage. A patient takes his morning insulin, and then, for some reason which may not be related to the diabetes, he vomits his breakfast Appreciating his need for carbohydrate he tries orange juice repeatedly but finds that he cannot retain that either He needs the help of his physician since it is obvious that, under these circumstances, carbohydrate will have to be given by another route to prevent the insulin reaction If the urme contains sugar, it suffices to start with an intravenous infusion of 1,000 ec. of 5 per cent glucose. Should the unne be sugar free, an additional 50 cc. of a 50 per cent glucose solution should be infused. The patient's urine must be examined frequently, but as long as glycosuria is present without any other symptoms of diabetes, no additional treatment is required. In many cases, if no food is ingested the vomiting ceases in twenty four hours, and the former regimen may then be resumed. An emergency of this type is best treated in a hospital

It is obvious that the emergency caused by relative insulin overdosage should be prevented but when it occurs, it should be treated in its carliest phases. If unusual activity is anticipated, such as a dance, golf tennis, riding, or swimming, reduce the morning dose of insulin by 10 units, and, in addition advise more food than usual after the activity.

A most terrifying emergency is the profound insulin reaction, absolute or relative, which is

associated with partial or complete loss of con-While this condition can also be treated at home, the patient is far better off in the hospital. The most effective measure is glucose given intravenously. It should be given continuously, either as a 5 or 10 per cent solution, until sugar appears in the urine Chnical signs of recovery appear slowly and may not be very impressive for hours after the appearance of sugar in the urine. Careful observation, however, will reveal encouraging signs. The patient may respond to such simple requests as to move an arm or leg, and he may also attempt to take fluids by mouth when they are offered Not infrequently, during the comatose period, one finds acetone but no sugar in the urine. Under no circumstances should insulin be given One must not be misled by the finding of acetone, for it may be a result of starvation. If there is no sugar in the urine, there is the indication for glucose, orally parenterally, or by both routes. If the hypoglycemic syndrome is caused by an overdosage of regular insulin, a subcutaneous injection of I cc of epinephrin (1 to 1,000) may revive the patient sufficiently to enable him to take fluids by mouth. The response to epinephrin in cases in which protamine sinc insulin has been used, however, is not satisfactory Quite the contrary, the epinephrin may aggravate the ketonuria and further complicate the picture.

The emergency arising from too little insulin is more serious. It is due to keto-acidosis and may result in coma. The insulin insufficiency may be absolute or relative Absolute insulm mauffi ciency occurs during the course of the disease if it is not treated or in the diabetic under treatment who fails to take the insulin systematically He may omit the insulin because of spitefulness or capriciousness he may have broken his syringe, or needle, or he may have used up his supply of ınsulin It may seem incredible that the ad ministration of insulin is discontinued for such reasons, but it nevertheless, does happen. Some patients pay dearly for their carelessness by the development of diabetic acidoes But somehon some of these patients cannot or do not wish to learn or profit by their expenence. Such lapses occur even though the physician has taken all the necessary pains to impress upon the patient never to discontinue insulin unless so advised by

Relative insulin insufficiency may also be caused by infections and such complications as hyperthyroidism acromegaly, and Cushing's syndrome. I use the broad definition for the latter term in which the adrenal gland may also play a role. With the development of any such complications, the efficacy of insulin is reduced, and consequently, a dose which may have been

sufficient previously now becomes inadequate The resulting keto-acidosis may be mild, moderately severe, or severe

The Mild Case — The trained diabetic patient under observation will usually feel well, maintain his weight, and carry on free of symptoms, and although he may have glycosuria, he will have no acetone in the urine. After a slight upper respiratory infection, a gastrointestinal upset, or severe sunburn, and sometimes even without apparent cause, thirst may appear, the volume of urine may rise, and acetone may appear in the urine. The amount of acetone may be 1 to 4 plus. Such a patient need not be hospitalized. He is usually familiar with the tests for acetone and sugar and can manage the treatment at home. He is given these directions.

- 1 Test all urme specimens for sugar and acetone
- 2 After each voiding, if acetone is present, take regular insulin in amounts depending on the quantity of sugar found in the urine, if the color in the test is yellow, brown, or orange take 25 units, if the color is green with yellow sediment, take 15 units of insulin, if it is blue, indicating that the urine is sugar-free, take only the juice of an orange
- 3 Drink all the fluid you can, water, milk, fruit juices, ginger ale
- 4 Take salty broths, or if they are not available, take two salt tablets (0.5 Gm each) every two hours
- 5 Continue this treatment until three consecutive specimens are acetone-free If acetone persists and you are nauseated or vomit, come to the hospital at once

With such home treatment the ketosis usually clears rapidly, and after the underlying cause disappears, the patient may return to his former regimen In cases in which the ketosis appears without any evident cause, I have learned that, generally, an increase in the daily dose of insulin remedies the situation I want to state categorically that every patient in whom ketosis is present when the diagnosis of diabetes is first made, regardless of the seventy of the disease, should be hospitalized This is necessary chiefly because of the patient's lack of training Because of hospital overcrowding, however, I have treated some of these cases at home. Here the help of a nurse or a member of the family is urgently needed I teach them the routine of urine testing leave specific written instructions, keep in touch with the patient by telephone at hourly intervals, and visit the patient as often as I can

The Moderately Severe and the Severe Case —The moderately severe case of keto-acidosis may reveal a pattern similar to the following. The patient may be one whose diabetes is recognized

and well cared for with insulin and diet He develops assore throat or some other infection develops a fever and malaise and loses his interest When he eliminates a meal, he also omits the insulin to avoid a reaction For a few days, he may subsist on only fruit juices and other fluids, omitting the insulin during this time, reasoning that under these circumstances insulin Thirst and frequency of is still unnecessary urination soon appear There develops aching of the legs, weakness, restlessness, and perhaps some somnolence It may be followed by epigastric pain, nausea, and vomiting The heart beats rapidly, and there is difficulty in breathing. He or some member of the family finally becomes alarmed Sometimes, however, no medical aid is sought until the patient is unconscious, occasionally not for many hours Such a patient should be taken to the hospital The infection should be treated in the usual manner with a specific chemotherapeutic agent, if it is applicable The diabetic acidosis should be treated as follows

- 1 If the patient is unconscious, insert a catheter into the bladder and clamp the free end, to make it easier to obtain samples of urine
- 2 Give 25 units of regular insulin subcutaneously every half hour until the clinical symptoms of ketosis begin to subside, and the unne becomes acetone-free
- 3 If the patient can take and retain fluids, give one or two glassfuls of fruit juice every hour or even every half hour. The patient is urged to take salty broths and other liquids as frequently as possible
- 4 If fluids cannot be taken by mouth, give a rapid intravenous infusion of 1,000 cc of 5 per cent glucose in physiologic saline at once. After that, and until the oral route can be used, infusions are continued at a slower rate. Care must be exercised to prevent overloading the heart, especially in the case of older diabetics with arteriosclerosis or in those known to have heart disease.
- 5 After the urine has become free of acetone, continue 25 units of insulin and two glasses of orange juice every two hours for four or more doses

While other plans may be advised elsewhere, we have used this one with eminently satisfactory results during the last fifteen years

DR. CATTELL Dr Tolston is ready to answer questions or to receive comments on the plans for the treatment of emergency disorders occurring in connection with diabetes

DR HARRY GOLD Did I understand Dr Tolstoi to say that in diabetic acidosis, he uses infusions of sodium chloride solution?

DR. Tolstoi That is correct

DR. GOLD Does he ever use a solution of sodium lactate instead of ordinary physiologic white, and if so, when and how much?

Dr. Toteror We sometimes use sodium lac tate, but it is not part of our standard routine I think we do just as well with the saline and glucose In the patient with Leto-acidous, I believe that the most important agent is insulin, next in importance is fluid. Since the total dose of insulin is large in these cases the use of glucose insures against the patient passing from diabetic acidous to hyporlycemic shock.

Dr. CATTELL You do not think it necessary to correct the acid-base disturbance directly, is that it?

Dr. Toleror We do not. We have not had much difficulty due to disturbances in electrolyte equilibrium. Dr Cattell The cause of diabetic acidesis is the production of excessive amounts of ketone bodies They are excreted in part, in combination with ammonia, the production of which is increased, and, in part, in combination with fixed base thus drawing on the body stores of base. If we reduce the production of ketone bodies, we have a means of controlling the acidosis. The overproduction of ketone bodies takes place when the diabetes is not under adequate control In this state, the body metabolises more than the usual amount of protein and fat. There is experimental evidence which shows that, if ketone bodies reach let us say, 60 or 70 mg per 100 cc of blood 50 Gm of glucose given intravenously will by itself reduce the ketone bodies to 30 or 40 mg per 100 cc The combined use of insulin and glucose increases the rapidity of glycogen deposition in the liver

Dr. CATTELL Are there any occasions when you believe you must treat the acidosis directly because the blood pH is so low? Don t you prefer bicarbonate any more in such cases?

Dr. Torstor We don't determine the blood pH. We use the acetone in the unine as our chief guide to therapy and the progress of the disease.

Dr. CATTELL But you did use sodium blear-

bonate some years back?

Dr. Tolstoi Yes I know In the pre-insulin era, for the diabetic in acidous we did use bicarbonate. We were never quite sure whether it did any good, and in the treatment there was a great deal of vacillation. When such a patient received bicarbonate of sods and died we would may "We will never use bicarbonate again." Then came along the next patient in whom the bicarbonate was withheld, and when he died in acidosis, we found ourselves saying 'T e ought to have used bicarbonate

The advent of insulin has changed the situa tion. Now the vast majority of these patients recover However we still encounter cases of

keto-acidosis associated with shock and anuria In two or three such cases, we sought the advice of Dr Van Slyke, and it was his opinion that bi carbonate was indicated. But I remember a similar case in which bicarbonate was not used and the nationt recovered after anuria lasting several days. She received only transfusions, insulin, and infusions.

Dr. Francis Greenspan A little over a year ago, a case was described in the literature, in which the intensive treatment of diabetic acidosis by means of glucose, saline, and insulin brought about marked improvement in the symptoms and signs of the acidous, with restoration of the normal carbon dioxide combining power and disappear ance of acctone and discetic acid from the urine. However, some hours later this was followed by marked respiratory distress with rapid and shall low breathing which progressed to the point of paralysis of the respiratory muscles, and the patient was placed in a Drinker respirator The administration of potassium chloride to this patient brought about dramatic improvement and recovery This patient had fairly low serum potassium, 2.5 milliequivalents or 9.8 mg per 100 ce

I wonder whether acute notassium deficiency might not be responsible for the few cases of diabetic acidoes who die in spite of the fact that the acidous itself is brought under control? Might it be desirable to add potassium to the infusions or to use Ringer's solution in cases of prolonged acidous?

Dr. Toleror There are many factors which lower the level of the serum potassium, and thus may be associated with profound cellular changes. since potassium is an intracellular base. It has been found low in coms, and there are several observations indicating that the administration of glucose and insulin favor the lowering of plasma potassium. I recall the case to which you referred. I believe it was the report by Holler of Rochester in the Journal of the American Medical Association, August 10 1946 I believe it is the only case of the kind on record Potassium deficiency may well be a factor in some of these cases of diabetic acidosis, and the administration of a few grams of potassium may be important, but I have had no experience with it and know no more about it than was presented in the publication you mentioned We may learn more about potassium in diabetic coma, since a less tedious technic for its determination is now available I have in mind the spectrophotometer as a means of analysis. Further than that, I cannot answer your question

The duration of the come appears to be directly related to the likelihood of recovery If a patient has been unconscious for more than ten hours, the chance for recovery is about 50 per cent, if more than sixteen hours, the chance for recovery is reduced to about 10 or 20 per cent. On the other hand, in conscious patients, recovery may be expected in about 99 per cent of the cases

DR GOLD I would like to come back to the question of the use of sodium chloride as distinguished from sodium bicarbonate or sodium lactate It would seem to me that sodium bicarbonate and sodium lactate might neutralize acid directly, while sodium chloride would reduce acidosis indirectly In the patient with advanced keto-acidosis, there would appear to be at least four sources of trouble, namely, the damaging effect of excessive acid or lowered pH, the specific toxic effect of excessive ketone bodies in the blood, a state of dehydration, and the secondary effects of dehydration in the form of circulatory failure and breakdown of renal function have just heard of still another element, low blood potassium These factors are interrelated There is some evidence that the coma resulting from the injection of acetoacetic acid is not solely the result of the increased acid but partly the result of a toxic effect of the acetoacetate ion The normal individual may excrete fixed acid equivalent to about 800 cc of tenth-normal acid per day diabetic acidosis, it may increase to ten times as The marked increase in production of acid exceeds the capacity of the kidney to produce ammonia for its neutralization, and among the adaptive mechanisms, the fixed base or the sodium in the blood is called upon so that the bicarbonate level of the blood falls The loss of sodium base leads to diuresis and dehydration, and excessive dehydration may lead to circulatory and renal failure The administration of infusions of sodium chloride would seem to be the proper method for restoring blood volume and extracellular fluids and in that way correct the circulatory failure which may have been responsible in part for the breakdown in renal function This should have the further effect of lowering the acidosis, because one of the functions of the kidney is to produce ammonia for the maintenance of acid-base equilibrium, and a kidney in which the circulation is greatly impaired may not be in a position, among other things, to produce enough ammonia The use of sodium chloride infusions would, therefore, seem to be an indirect method, although a vital one, for correcting However, I wonder whether this may be enough in the more advanced cases, and whether, in these, an additional supply of base without a p'rong acid ion, as would be the case through tieratse of sodium bicarbonate or sodium lactate, misse not be helpful in counteracting the damaging effect of the acidosis per se by direct neutralization of the acid and thereby save some of those cases which are lost when treated with saline infusions alone I know of no method for counteracting the specific toxic effects of excessive acetoacetic acid

DR Tolstor We have treated patients with carbon dioxide combining power as low as 5 volumes per cent, a state of pretty deep acidosis, although not necessarily one producing unconsciousness, with salt alone in addition to insulin and glucose, and they have re-On the other hand, I can recall the covered case of a patient who was unconscious for ten or twelve hours and who died despite the fact that he received salt, sodium lactate, blood, and all of the adjuvants we know, in addition to usual doses of insulin and glucose Theoretically, you may be right, Dr Gold Your explanation is attractive, but practically it works out that, if the patient is conscious, we need use nothing but insulin, glu-In the discussions on the need cose, and salt for glucose there has been a good deal of As I stated, I think heat but very little light insulin is the most important agent The fluid and what it contains are of lesser importance I have not had enough experience with lactate, however, to argue for or against it

DR CATTELL If the patient's kidneys were not functioning at all, the sodium chloride would have little effect in directly overcoming the acidosis, because the chloride and the sodium base would be retained

DR GOLD As I stated, the sodium chloride infusions might still be effective indirectly, because by correcting the dehydration, renal function might be resumed

DR Tolstor When there is anuma due to blood pressure falling to shock levels, the patient's chances for recovery are very poor indeed. I think both Dr Cattell and Dr Gold have presented a sound argument from a theoretic point of view. However, when these patients are treated in the way I have outlined, the results are very satisfactory.

In a five-year period, 100 cases were treated in this hospital, chiefly by the house staff, not by $\mathfrak a$ team of specialists They did a fine 10b Among the 100 cases, there were seven complicated by other conditions which could have caused the fatal outcome, namely, meningitis, acute coro-There were nary closures, intestinal obstruction only two deaths due to the acidosis per se of those was a patient with unusual resistance to insulin, who required several thousand units of insulin daily to abolish the acetone, the other was one who entered the hospital after being unconscious some ten or twelve hours had been treated by a Christian Scientist and then when the situation got out of hand, she was brought here All cases were treated principally

with insulin, galine, and glucose. In those in whom the situation appeared desperate, how over, blood and sodium lactate were used as well

Visiron It seems to me that Dr Gold has made out a much better case for the use of sodium bearbonate than for sodium lactate true that good liver function is required to utilize the lactate and thus to make sodium available to the patient. It would seem to me. therefore, that in a desperate case, it would be advisable not to rely on the liver and to give the bicarbonate

Dr. Gold I would agree with that

DR. N T Kwir In the event that one wished to use sodium lactate or sodium bicarbonate. what doses would one give?

Dr. Gold There is a formula for calculating the amount of one-sixth molar sodium lactate rolution necessary It is based on the value of the carbon dioxide combining power and weight of the patient. However satisfactory results may be obtained by an intravenous infusion of 30 cc of the one-earth molar lactate per Kg and repeated if necessary Such a dose may increase the sodium ion concentration of the blood plasma about 7 mm, per L , corresponding to an increase in the bicarbonate concentration sufficient to raise the value of the carbon dioxide combining power of the blood plasma by approximately 15 volumes per cent The counvalent of this in the form of sodium hienrhonate would be about 0.4 Gm per Kg., or a total of about 25 Gm for the average adult.

Dr. Cattell I wonder whether we know how important the acidosis per se is among the dangers in this condition. Do you consider the acidoms the primary cause of the coma?

Dr. Toleroi I do not know the role of the acidosis per se, it is certainly not the sole factor Consider the case of some patients who come into the hospital in diabetic acidosis and are unconscious. The blood picture may be characteristic high blood sugar, low carbon dioxide combining power, and acetone We have observed the course at hourly intervals in these, as others have done. The abnormalities were corrected the carbon dioxide combining power would rise to 50 volumes per cent and the ketone bodies would disappear from the blood and urine, but some of these patients would die. There may have been no kidney shutdown Why such patients die I don't know I once asked for an explanation at a meeting of eminent workers in the field, but no one seemed to have any

Dr. Gold How do they die! What happens to them?

Dr. Tolston They just keep on breathing faster and faster and finally die.

Dr. Gold Is it circulatory failure, respiratory failure pulmonary edems or what?

Dr. Tolstor An hour before death, in a case which I recall very clearly, there were no evi dences of circulatory failure. A physician was observing the patient most of the time blood pressure was maintained until about an hour before death. We had no idea what caused death in this case. Postmortem examinations in similar cases have revealed nothing specific.

Dr. SEYMOUR H. RINZLER May I ask what one does in the case of the cardiac who is in ketoers and in whom sodium is contraindicated because of congestive failure?

Dr. Toleroi Acidoris is a very effective dehydrating factor, and these putients are fairly well dehydrated This can be judged from the high hemoglobin, as well as from the general appearance. Congestive failure is, therefore, not a common problem. In cardiac patients I give the fluid very slowly to avoid overburdening the heart. In older patients, I sometimes give it aubcutaneously.

Dr. Ringler Do you not worry about retention of sodium?

DR Toleror No. I don't.

DR. GOLD Congestive failure is a condition in which there is tissue hyperhydration, too much extracellular fluid Severe keto-acidosis of the diabetic is a condition in which there is dehydration, too little extracellular fluid Theoretically. it should be impossible for the two to occur amul The situation however, is more taneously complex for there are occasional cases of congestive failure with severe diabetic acidosis and coma, in which pulmonary edema develops. It may be that in some even advanced acidosis is not sufficient as a dehydrating factor and that the factors other than dehydration play a more important role in the causation of the come of the keto-acidosis. In the few that I have seen, I have relied on the insulin and sugar to correct the acidosis, and on the mercurial diuretic to combat the pulmonary edema, even though the diuretic leads to a further loss of sodium There is, of course always the possibility of an error as to the cause of the coma I do not know how to make sure of it. These are patients with long-standing congestive heart failure and long-standing dia betes, who develop come without clear evidence of a cerebral accident, and in whom one finds a very low carbon dioxide combining power a high blood sugar, and sugar and acctone in the urine. They sometimes have an arotemia so that one remains uncertain as to whether the coma is caused by uremic or diabetic acidosis

In this connection, another problem might be worth mentioning When renal failure complicates chronic heart disease with diabetes, the patient may develop edema and effusions These suggest congestive heart failure They may, however, be the result of the retention of sodium, in the individual whose damaged kidneys cannot The retention of sodium excrete enough acid Attempts to treat the edema by leads to edema mercurials or other diuretic measures may give rise to mental disturbances, unrest, and prostration which may progress to coma When seen, the patient may present the evidence of diabetic acidosis, renal failure, and coma, and the coma. while due to an acidosis, is not caused directly by either diabetic or renal acidosis but by the treatment attempting to control the edema, counteracting thereby a possible protective mechanism of sodium (and with it water) retention

DR WALTER MODELL How do you treat the diabetic emergency that develops as the result of a serious acute infection?

Dr. Tolstor In exactly the same way as I have outlined Let us say that in a case of pneuthe diabetic patient's compensation breaks The established routine for the control of diabetes is abandoned We switch from protamine zinc to regular insulin The urine is examined for sugar as often as the patient voids When the test shows 4 plus, we give 25 units of insulin, when it is 2 or 3 plus, 15 units of insulin, and when the urine is sugar-free, we give orange The pneumonia is treated with penicillin After the infection subsides and the abnormal urnary findings disappear, the patient returns to his former regimen

DR CATTELL Can the patient be forewarned about this, and be taught to take care of himself in relation to acute infections?

Dr Tolstoi We do that, Dr Cattell If the patient has a cold or other infection, he knows enough to be on the lookout for acetone. Life is now very easy for the diabetic patient as well as for the doctor. There are powders on the market for testing for acetone, the Galatest powder. All the patient does is to put a little powder on a piece of paper and a drop of urine on it. If it turns purple, it is positive for acetone, in that event, the patient follows the established routine, testing the urine until the powder remains white when urine is added. In our clime, when we find acetone in the urine, our patients usually know what to do without further instruction.

Dr. Modell What would you advise a chabetic patient who has suffered a serious burn, in unticipation of a break in diabetic compensation?

DR Tolstor I would tell him to examine the urine for sugar and acetone, and if acetone appears, to take regular insulin in accordance with the plan I have outlined, until the acetone disappears

DR CATTELL You would not ask him to readjust the dosage with the expectation that there was going to be a break in the diabetic compensation?

DR Tolston No, I don't think so, at least we have not done it yet It may be a good idea to do that

VISITOR Do you believe there is a place for globin-insulin with zinc in the treatment of medical emergencies?

DR Tolstor No, I do not None of the slow acting insulin preparations should be used in an emergency. The only insulin to be used in emergencies, in my opinion, is the regular soluble crystalline insulin, a material which produces its effects quickly. One ought not to wait six or eight hours for an effect in a critical situation.

DR CATTELL Do you give insulin intravenously?

DR TOLSTOI We hardly ever give it intravenously Once in a while we put 25 units of insulin into a glucose infusion, but otherwise, it is given only subcutaneously

DR GREENSPAN In the case of a patient who enters the hospital with acidosis and severe insulin deficiency which has persisted for some time, might one give somewhat larger initial doses, say, 50 or 100 units?

DR Tolstoi I am glad you asked that question The initial dose of insulin ranges from 25 to 400 units in different clinics. When small doses are given, the intervals are short, and when larger doses are used, the intervals are longer. We give 25 units as the first dose, Peters of New Haven gives a 50-unit dose, Olmsted of St. Louis gives 100 units, waits an hour and a half, and determines the blood sugar to see whether more is needed, Rabinowitch of Montreal gives 400 units, 200 units of protamine zinc insulin and 100 of regular insulin subcutaneously, together with an intravenous infusion of 100 units of regular insulin, and very large amounts of glucose

Our results are very satisfactory, but that does not mean that our method is superior to that of others. There are many factors which may determine the result. For example, Owens of Cincinnati, using schedules of 50-unit doses of regular insulin and careful clinical and laboratory observations as guides, has, nevertheless, had a relatively high mortality rate. This may be explained by the fact that he receives his patients from an ambulance service. Such patients are likely to include a considerable number who are neglected and who may be in a more advanced state of acidosis with more profound coma than most of ours.

Education is important in preventing acidosis. We instruct our patients to come to the hospital

the moment they suspect an infection or any unusual situation. They may even give themselves an extra does of insulin before starting for the hospital. In most of our cases, the ketosis disappears in about 6 hours because it is already under control on admission.

Dr. Greenspan Do you ever use larger doses of insulin than you indicated in your plan?

Dr. Tolstor I do not.

Dr. GREENSPAN? Do you believe that all emergencies can be managed with only 25-unit doses of insulin?

Dr. Tolstor I do

Dr. Greenspan That is a debated point

Dr. Tolstoi My own experience leaves me no reason for changing my view. I see no objection to using does of 100, 200, or even 300 units if one knows the objective. I can only say that our very satisfactory results have been obtained with small doses given frequently.

INTERN If a diabetic who is controlled with protamine and insulin, develops an occlusion of a coronary artery would that after the procedure? Would you not change from protamine sine

insulm to regular insulm?

Dr. Toleror I don't think I would. I would just make certain that glycosura is present and no symptoms of diabetes. I would make no change in the regimen unless there were definite indications such as ketosis.

Visitor I want to ask Dr Tolston whether he favors the two-syringe or the single-syringe technic for patients who receive both the regular

and the protamine zinc insulin

Dr. Tolstol When one can reduce the number of injections, one should do it. Remember the year has three hundred sixty five days. When both are necessary I mix them in one syringe and make only one injection instead of two. It spares the patient much discomfort over the years. The mixture which I have found most successful is the two-to-one mixture, two parts of regular and one part of protamine sine insulin

Dr. Gold How would you distinguish dia betic come from insulin come in an unconscious lady in the ladice room in Macy's department

store?

DR Tolsfor The lady in diabetic come is apt to have a dry and flushed skin, a fruity odor of the acetone breath, soft eyeballs, and a red tongue. She may have the typical air hunger or kusamaul breathing Diabetic acidosis develops alowly, and hours elapse before come develops. A person with ketosis so serious as to verge on come is not apt to be shopping in Macy's

Insulin shock, on the other hand is encountered quite frequently in department stores. In such a person the skin is apt to be moist and pale, the cycballs are not soft and air-hunger is absent.

This person is more apt to have twitching or convulsive movents. A positive Babinski may be present. The turne analysis will very quickly disclose what the condition is In diabetic comathere will invariably be glucose as well as acctone, while in the case of insulin coma, the turne will be sugar-free and probably acetone-free as well at though occasionally acetone may be present and sometimes even sugar when the bladder contains urine secreted several hours previously

DR. GOLD Would you have any heatation in proceeding to treat this person with insulin as a case of disbetic acidosis, on the basis of the clinical differentiation you presented, if you were not in a position to examine the urine?

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Dr. Tolstoi Oh but I would have to have a urine specimen.

DR. Gold But you can't have it.

DR. Totsroi I know that in Macy's I could get a specimen of urne, but if I couldn't, I think that our technic of small doses of insulin adequately covered with glucose is ideal. With this procedure one cannot get into any trouble, and one can carry the patient along until it becomes possible to obtain a specimen of urine

Intern Would the blood pressure help in this

case?

Dr. Tolstoi Not as a rule

DR. GOLD Has solution of posterior pituitary any place in the treatment of an insulin reaction?

Dr. Toleror Yes, it is a direct antagonist to insulin as is epinephrin. Both of these are of value in the case of a reaction to regular insulin but not very effective in the case of protamine sinc insulin.

DR. CATTELL What is the basis for the difference?

DR. Tolsroi It is due to the difference in the speed of action of the two forms of insulin. Regular insulin is rapidly absorbed, and its peak effect is prompt. The rapid fall in the blood sugar may give rise to an insulin reaction at a time when the level of the blood sugar is still in the normal range. It is the rapid change rather than the absolute level of the blood sugar which may cause a reaction in the case of regular insulin Furthermore in such a case, stores of glycogen may still remain in the liver The epinephrin is effective here because it exerts its action by the release of glycogen from the liver. In the case of protamine sinc insulin epinephrin is less effective because this form of insulin acts very slowly, and before symptoms of insulin reaction are appreciated the blood sugar has fallen to 30 or 20 mg per 100 cc, and the glycogen of the liver has been In the absence of liver glycogen neither epinephrin nor pituitary solution has any effect on the insulin reaction. There is also the fact that protamine zinc insulin remains long at

the site of injection, and when epinephrin relieves the insulin reaction in this case, it is likely to be only temporary because of the continued absorption of the insulin over a long period of time

VISITOR Would Dr Tolston say something about the preoperative preparation of the dia-

betic patient?

Dr Tolstoi I think that no diabetic patient need be denied surgery at any time, whether it be an emergency operation or one of election One must make sure of the diagnosis before operation For example, a good many cases of diabetic acidosis present a picture that is difficult to differentiate from acute appendicitis In case of an emergency, before operation the patient should be given insulin, if necessary, and observed for a little while When there is acidosis, if it is possible, it is well to wait until the acetone begins to diminish The patient is taken to the operating room and there given 25 units of regular insulin together with an intravenous infusion of 1,000 cc of 5 per cent glucose in saline. As soon as the patient returns from the operating room, another dose of 25 units of insulin together with an intravenous infusion of 1,000 cc of 5 per cent glucose in saline are given. If the patient is unconscious. a catheter is inserted, clamped, and specimens of urine are collected every two hours If the coma is due to diabetes, the routine which I have already outlined for the comatose diabetic patient 18 followed

In the case of an elective operation, the preparation aims at achieving two results, namely, satisfactory hydration and abundant glycogen storage in the liver. The hydration is obtained by means of 1 Gm of salt (2 tablets of 0.5 Gm each) followed by a glass of water every three hours. To secure glycogen deposition in the liver, I usually give a glass of orange juice and 10 units of regular insulin every three hours on the day before operation. This results in a glycosuria, but the presence of sugar in the urine is a matter of no concern so long as the patient's needs for glycogen and water have been met

Summary

Dr. Gold The conference this afternoon dealt with the treatment of some specific emergencies which arise in the diabetic patient. The chief medical problems requiring urgent treatment in the diabetic patient are due to either too much or too little insulin. The conditions which bring about these two states were considered,

such factors as errors in dosage, unusually vigorous physical exertion in a patient otherwise well maintained, acute infections, burns, and gastric upsets. In general, it seems that reactions to excessive insulin are more frequent, they appear more abruptly and are apt to be less serious than the emergencies due to insufficient insulin. The emergency due to insufficient insulin is apt to develop slowly and insidiously

The two types of cases often present striking clinical differences In the reaction due to too little insulin (keto-acidosis), the skin is apt to be dry and flushed, the eveballs soft, the tongue red. the fruity odor of the acetone breath may be perceptible, and the typical air-hunger or Kussmaul breathing may be present In the reaction due to insulin overdosage, the skin is apt to be moist and pale, the eyeballs are not soft, air-hunger is absent, muscular twitchings may be in evidence, and a positive Babinski sign may be elicited Coma may be present in both cases cisive differential diagnosis between the two conditions depends on an examination of the urine for sugar and acetone and an examination of the blood for sugar and carbon dioxide combining power Sources of error in the interpretation of the findings were discussed

Emphasis was placed on the need for educating the diabetic patient in the matter of diet, dosage of insulin, and examination of the urine for sugar and acetone, so as to enable him to recognize the reactions in their earliest forms, to take adequate precautions to prevent them, and to take the first steps in controlling a reaction promptly In the case of insulin overdosage, the essential treatment is the administration of readily available sugar in the form of orange juice or parenteral In the case of the emergency due to insufficient insulin or diabetic acidosis, the essential treatment consists of frequent doses of insulin, glucose, and the administration of salt and water either by the oral or parenteral route details of the treatment were fully discussed

Several other matters involved in the medical emergencies of the diabetic received attention, namely, differences in the reactions to regular and protamine zinc insulin, the underlying disorders in diabetic acidosis, the mechanisms by which the disturbances may be reversed, comparison of sodium chloride with sodium lactate and sodium bicarbonate in the control of diabetic keto-acidosis, the role of low blood potassium in the cause of disasters, and the preparation of the diabetic patient for operation

MEDICAL NEWS

Dr. Ralli Re elected Women's Medical Association President

DR ELAINE P RALLI associate professor of medicine, New York University College of Medicine, was re-elected president of the Women a Medical Association of New York City at its annual

meeting April 29 for a two-year term.

Other officers elected were vice-president Dr Leonl N Claman, secretary, Dr Margaret S Tenbrinck and treasurer Dr Helen Neave Combloed with the business meeting was the annual Spring Dinner of the organization and a scientific talk followed by open discussion. Guest speaker was Dr Elith II Quimb, Ph D associate professor of radiology Columbia University who spoke on the topic "Medical Uses of Atomic Energy

Dr Ralli is a member of the American Physiological Society the Society for the Study of Internal Secretions, the American Institute of Nutrition and the New York Academy of Medicine She graduated from Now York University College of Medicine in 1925 and is now in charge of the College's Metabolic Clinic.

Medical Service Reserve to Place 300 on Active Duty

A UTHORIT1 has been granted the Army Medical Department to place immediately 300 additional Medical Service Reserve officers on extended active duty it was announced recently by Major General Reserve officers who volunteer will be assigned to duty in all four sections of the Corps according to their qualifications. The greatest need is in the Medical Allied Science Section which in cludes personnel trained in psychology physiology, hiochemistry nutrition, serology and other related medical sciences needed in the Army

The recent formation of the Medical Service Corps so ne phase of a long range program designed to provide the highest possible standard of medical care for the U.S Army with a minimum number of physicians required in administrative positions or performing duties properly belonging to medical allied sciences.

While specialists in fields embraced by the Corpe have always sorved in the Army, authorities felt that the former administrative setup did not make for the fullest use of talent or the highest degree of individual satusfaction

British Nobel Prize Winner Lectures at Medical Center

CIR Henry Hallet Dale past president of the Royal Society of England and a winner of the Nobel prize in 1930 gave a lecture under the joint sponsor hip of the New York University Bellevie Medical Center and the Post-Graduate Medical School on Tuesday April 20 His lecture was the first to be presented under a grant from the Samuel H. Kross Foundation made for the purpose of stimulating an international exchange of medical information and postgraduate training of physicians.

The title of Sir Henry's lecture was Chemical Transmission of Nervous Effects It was delivered in the main lecture hall of the New York University College of Medicine

The Samuel H. Kress Foundation last month made a grant of \$162,000 to be utilized in integrating and oxpanding the poetgraduate training programs of the New York University-Bollovue Medical Center and the Post-Graduate Medical School At that time it was announced that an agreement had been reached looking toward a union of the two institutions and the formation of a new College of Post-Graduate Medicine as a unit of the Medical Center

Scholarship in Oral Pathology

THE New York Institute of Clinical Oral Pathology has established an annual scholarship of \$1 000 for research in clinical oral pathology Those interested will please communicate with the Executive Secretary G Roistacher 101 East 70th Street, New York 21 New York

Doctor s Orchestral Society Gives Concert

THE annual concert of the Doctors' Orchestral Society of New York was held May 13 at the Hunter College auditorium, with proceeds from the concert donated to the Physicians' Wives League of Greater New York for their charitable and educational programs.

A symphonic group composed of 70 doctors dentists, and members of allied professions the Doc

tora Orchestral Society has presented a concert cach year for a worthy cause Feature of this year's program was the world premiere of an or chostral suite. The Hospital composed by Dr Herman Parris of Philadelphia, Pennsylvania. An I'NT specialist at the University of Pennsylvania Dr Parris has been composing orchestral and in strumental works for many years.

Camp Doctors Wanted

THE Camp Unit of the New York State Employment Service is recruiting doctors for summer

camp employment at children's camps

A New York State medical license is required for employment in New York State or another state license for camps located outside of New York State

While most all positions are for the two months of July and August, there are a few for which doctors

for one month only will be accepted

Based on past experience and prospects for this

year, camp directors will not consider married physicians who must have husband or wife with them, except when the spouse has experience and will work as a counselor or a nurse Few camps have facilities for accommodating a physician's family as guests

All doctors interested in camp employment should apply in person at the Camp Unit, 139 Centre Street, New York City The hours for in-Centre Street, New York City The hours for in-terviews are from 9 until 5, Monday through

Friday

Division of Toxicology Established in Buffalo University Medical School

THE establishment of a Toxicology Division and Toxicology Laboratory in the Medical School of the University of Buffalo has been announced by Dr Stockton Kimball, dean of the University

According to a recent report, the new unit will be supported jointly by the University of Buffalo and the County of Erie, and will work in close cooperation with city and county authorities Few medical schools have such laboratories

Dr Niels C Klendshoj, associate in pathology in the medical school, will be the director of the Toxicology Division Dr Milton Feldstein of New York, who has had experience in this field at Bellevue Hospital and in the Army Sanitary Corps, will be in charge of the chemical laboratory

Chapin Fellowship for Study of Contagious Diseases

A PPLICATIONS for the Charles V Chapin Fellowship for the study of contagious diseases are now being received for 1948 with none to be accepted after September 1

The Fellowship provides for one year's research work pertaining to some phase of contagious

diseases, this research to be carried out at the Charles V Chapin Hospital, Providence, Rhode

Additional information may be obtained from the Superintendent of the Charles V Chapin Hospital, Providence, Rhode Island

Life Insurance Companies Make Research Awards

INITED STATES and Canadian life insurance O companies will give more than a half million dollars for research in heart disease during 1948, it was announced recently by M Albert Linton, chairman of the Life Insurance Medical Research Fund The awards raise to \$1,800,000 the total research subsidy provided through the Fund since it was organized in December, 1945

Thirty-one hospitals, medical colleges, and special research clinics in eighteen states and Canada will share \$484,790 in the grants announced by Mr Linton, and fourteen individual doctors will receive \$52,600 in postgraduate fellowships. All research is confined to diseases of the heart, arteries, and blood vessels which account every year for more than 45 per cent of deaths at all ages in the United States and more than half the deaths at ages over forty-five

The Fund is supported by 149 life insurance companies and is administered through a board of directors representing the life insurance business and an advisory council of medical research experts, the latter headed by Dr Francis G Blake, Sterling Professor of Medicine at Yale Scientific director of the Fund is Dr Francis R. Dieuaide, clinical professor of medicine on the staff of the College of Physicians and Surgeons of Columbia University

Among the fourteen fellows of the Fund appointed are Dr Mogens Faber of Copenhagen, Denmark, who will work at Columbia University in New York under the supervision of Dr Erwin Chargaff, and John L Webb, Ph D, of Pasadena, California, who will work at Oxford University in England under the supervision of Professor J H Burn The international exchange is the first sponsored by the

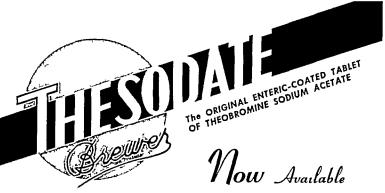
New York physicians receiving postgraduate research fellowships carrying stipends from \$2,500 to \$4,000 include Dr Edward E Fischel, New York City, to work under the supervision of Dr A R Dochez at the Columbia University College of Physicians and Surgeons, and John G Hawley, New York City, to work under the supervision of Dr Carl J Wiggers at the Western Reserve University School of Medicine

Grants in aid of medical research awarded in New York State are to Columbia University, for research by Dr Dickinson W Richards, Jr, on the action of cardiovascular drugs, \$21,000, for research by Dr Rene Wegna on the dynamics of the circulation, especially in the coronary vessels,

7,560
To Mount Sinai Hospital, New York City, for research by Dr Harry Sobotka on the chemotherapy of hypertension, \$21,000, to New York University, for research by Dr Norton Nelson on the distribution of readily diffusible materials, \$2,100

To Syracuse University, for research by Dr Robert F Pitts and Dr Richard H Lyons on renal function and circulatory dynamics in cardiovascular disease, \$21,000, for research by Dr Jane Sands Robb on the structure and function of the conducting system of the heart, \$8,400, and for research by Dr W W Westerfeld and Dr J M McKibbin on phospholipid patterns in tissues, \$3,675

[Continued on page 1184]



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[Continued from page 1182]

MEETINGS

PAST

Saratoga County Tuberculosis and Public Health Association

Dr Herman E Hilleboe, New York State commissioner of health, and Dr Joseph L Kiley, Saratoga, discussed "Should Counties Establish Health Departments as Recommended by the State" at a radio forum which was broadcast from Skidmore College, on March 29

With Dr Hilleboe taking the affirmative and Dr Kiley, the negative, the program was the feature of the annual meeting of the Saratoga County Tuber-

culosis and Public Health Association

Albany Medical College

"Socialized Medicine-Where Do We Stand?" was discussed by Dr William P Howard, professor of radiology and director of the department of radiology, Albany Medical College, at the alumni luncheon held during the annual clinical day program at the Albany Medical College, on April 8, in Albany

With Dr H Dunham Hunt, Saratoga Springs, president of the alumini group, in charge, other luncheon speakers were Dr R S Cunningham,

dean of the college, and Dr Carter Davidson, chancellor of Union University, Schenectady At the morning session, Dr Edwin L Crosby, director of Johns Hopkins Hospital, Baltimore, an alumnus of Albany Medical College, spoke on "The Hospital and Medical Care" Seven papers were also given by members of the faculty, many of them

New York Council of Surgeons

Dr Isidore Arons, attending roentgenologist, Bellevue Hospital, and director of the tumor clinic at Harlem Hospital, spoke on "Atomic Energy. Its Medical Application" at the lecture sponsored by the New York Council of Surgeons on April 20 at the Parkchester General Hospital, the Bronx

Saranac Lake Medical Society

"Brucellosis" was discussed by Dr Orin D Chapman, professor of bacteriology, Syracuse University College of Medicine, at the April 21 meeting of the Saranac Lake Medical Society, held at the Saranac Laboratory

At the April 30 meeting, Dr Herman E Hilleboe, New York State commissioner of health, spoke on

"Private Practice and Public Health"

Maternity Center Association

At the annual meeting of the Maternity Center Association, held April 22 in New York City, with Mrs Shepard Kreck presiding, the main address was given by Miss Hazel Corbin, R N, general director Her talk, "Life Begins at Thirty," out-

lined the activities of the Association during its thirty years of existence for the welfare of mothers and babies

Board, spoke on "The Responsibilities of Parenthood" Dr George W Kosmak, chairman of the Medical

New York Psychoanalytic Society and Institute

Given under the auspices of the New York Psychoanalytic Society and Institute and the Association for Psychoanalytic Medicine, a meeting in commemoration of Dr Abraham A. Brill's medical attainments was held April 29 at the New York Academy of Medicine, New York City

Dr George E Daniels presided, and speakers were Dr Nolan D C Lewis, Dr Fritz Wittels, and Dr C P Oberndorf Dr Oberndorf was chairman of the committee in charge, which included Drs Leonard Blumgart, Daniels, Richard L Frank, Phyllis Greenacre, Marion E Kenworthy, Philip Lebrary, Beatrage, Layers, Scades Loverd and Lehrman, Bertram Lewin, Sandor Lorand, and Adolph Stern

Association for the Advancement of Psycho therapy

At the regular monthly meeting of the Association for the Advancement of Psychotherapy, held April 30 at the New York Academy of Medicine, Dr Augusta Jellinek spoke on "A New Approach to Speech Disorders" Discussion was opened by Dr Walter Boernstein

State Charities Aid Association

The annual conference and business meeting of State and local committees on tuberculosis and public health of the State Charities Aid Association

was held May 11 and 12 in New York City
With Dr James E Perkins, managing director of
the National Tuberculosis Association, presiding,
the opening session featured a symposium on "The Promotion of Public Interest and Concern for Improving Health Instruction and Health Protection in the Public Schools of New York State" Dr George M Wheatley, from the welfare division of the Metropolitan Life Insurance Company, led the discussion

At the luncheon, Dr Herman E Hilleboe, State Commissioner of Health, spoke on "Working To-gether for Public Health" Speakers at the final gether for Public Health" Speakers at the final meeting included Dr Paul V Lemkau, director of mental hygiene study, Johns Hopkins University, School of Hygiene and Public Health, on "Some Mental Hygiene Aspects of Public Health and Public Welfare," and Dr Granville W Larrimore, the state of the Public Health and Public Welfare, and Dr Granville W Larrimore, the state of the Public Health and Public Healt director of the Public Health Education Office of the State Department of Health, on "The Challenge of Adult Health Education"

FUTURE

University of Buffalo, Metropolitan Medical Alumnı

University of Buffalo medical alumni in New York City, the surrounding counties of Westchester, Nassau, Suffolk and in New Jersey, are invited to a luncheon to be given by the Metropolitan Medical Alumni of the University on Friday, May 21, at 12 30 PM in the Manhattan Room East of the Hotel Pennsylvania, New York City

Members of the University's medical faculty will attend, and a program detailing the curriculum, plans for expansion, the building of a new Medical School, and other topics of interest will be presented, according to an announcement from the University

Reservations are to be made with Dr Louis Finger,

285 Central Park West, New York 24

[Continued on page 1186]



ESPECIALLY DURING

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PHOSPHORUS	0.94 Bat.	VITAMIN D	417 1 0
IRON	12.0 mg	COPPER	0.50 mg.

*Based on average reported values for milk.

[Continued from page 1184]

National Gastroenterological Association

The thirteenth scientific session of the National Gastroenterological Association will be held at the Hotel Pennsylvania, New York City, on June 7, 8, 9, and 10 The first three days will be devoted to the presentation of papers, and the last day will consist of clinics arranged in cooperation with the various hospitals in New York City

American Academy of Dental Medicine

The second annual meeting of the American Academy of Dental Medicine will be held June 12 and 13 at the Hotel Pennsylvania, New York City Dr Herman J Burman, New York City, will present a paper on "Disturbances of the Salivary Glands," and Dr H H Neumann, St Albans, will discuss "Types of Diet and Caries Incidence" All other speakers will be doctors of dentistry

For further information, address the secretary, Dr William M Greenhut, 124 East 84th Street,

New York 28

University of Pennsylvania, Medical Alumni

Medical Alumni of the University of Pennsylvania will hold a dinner at the convention of the American Medical Association in Chicago on June 23, at the Lake Shore Club. 850 Lake Shore Drive On ar-Lake Shore Club, 850 Lake Shore Drive rival in Chicago, alumni are asked to contact Miss Frances R Houston, executive secretary of the Medical Alumni Society, at the University of Pennsylvania registration booth

Willard State Hospital

A two-day psychiatric nursing and social service institute will be held at Willard State Hospital, Willard, New York, on June 2 and 3, under the auspices of the Rochester State, Syracuse Psychopathic, and Willard State hospitals, the latter institution serving as host under the direction of Dr Kenneth Keill

Speakers who will address the institute will in-Dr J L Moreno, Beacon, Dr Harry A clude Steckel, professor emeritus of psychiatry, Syracuse Medical College, Dr Harry E Faver, assistant director, Buffalo State Hospital, Dr Niles Carpenter, director, department of social work, University of Buffalo, and others

The motion picture on the treatment of psychiatric disorders, "Let There Be Light," will be shown through the courtesy of the Medical Department of the United States Army

PERSONALITIES

Retired

Dr Stanley W Sayer, district health officer in charge of the Gouverneur District, on April 7, after completing more than 30 years' service on the staff of the New York State Department of Health

Dr Alfred W Smallman, Ellicottville, at a testimonial dinner given by the Ellicottville Chamber of Commerce on April 14, in honor of his sixty years of practice which started in Ellicottville in 1888 Dr Smallman is believed to be the oldest practicing physician in western New York

Awarded

To Dr. Dilworth Wooley, New York City, blind member of the Rockefeller Institute for Medical Research, the 1948 award of the American Pharmaceutical Manufacturers Association, at the annual convention in Havana on April 12 to Dr Howard A. Rusk, chairman of the department of rehabilitation, New York University, the first annual Survey award, presented by Survey, journal of social work, during the 75th anniversary meeting of the National Conference of Social Work in Atlantic City on April 22

Appointed

Dr L Whittington Gorham, Albany, as professor of oncology at Albany Medical College, effective July 1, to develop a cancer detection clinic and direct the tumor teaching program Dr Esmond R. Long, director of medical research and therapy for the National Tuberculosis Association, to suc-ceed the late Dr Max Pinner as editor-in-chief of the American Review of Tuberculosis

Speakers

Taking part in a symposium on "Cancer of the Gastrointestinal Tract" presented before the Hudson County Medical Society in Jersey City, New Jersey, on April 6, were Drs John S La Due and Paul J Murison, "The Symptomatology of Gastric Cancer", Dr Juan M Jimenez, "X-Ray Diagnosis of Gastric Cancer", Dr Isabel M Scharnagel, "The Role of the Gastroscope in the Diagnosis of

Gastric Cancer", Dr William Trevor, "Sarcoma of the Stomach", Dr Robert J Booher, "Tumors of the Ampulla of Vater," and Dr George T Pack, "Methods of Surgical Treatment".

Dr J Burns Amberson, Columbia University, College of Physicians and Surgeons, on the use of streptomycin in tuberculosis, at the meeting of the American College of Physicians in San Francisco, California, April 22 Dr. Alfred K. Bates, director of the tumor clinic at Auburn City Hospital and a member of the Cayuga County Cancer Committee, a radio talk over Station WMBO on the work of Dr Dicran Berberian, assistant the committee professor of tropical medicine and parasitology at Albany Medical College, on "Missions in the Near East" at the Interchurchmen's Fellowship meeting in Albany, April 19 Dr Carl A Binger, psychiatrist at the Payne Whitney Clinic, New York Hospital, at the meeting of the American Ortho-psychiatric Association in New York City, April 13

Dr Theodore Drachman, deputy health commissioner of Westchester County, on "Public Health" at a meeting of the Croton Community Nursery School, Croton-on-Hudson, April 19 Dr John S La Due, on "The Diagnosis and Treatment of Tumors of the Lymphoid System" at the annual meeting of the Medical Association of the State of Dr John S Alabama, in Mobile, Alabama, April 16 D Theodore R Miller, on "Early Diagnosis of Cancer at a meeting of the cancer control committee of the Mercer County Medical Society in Trenton, New Jersey, April 8 Dr George T Pack, on "The Endocrinology of Neoplastic Diseases" at the annual symposium on cancer given by the Indiana Cancer Society at the Indiana University Medical Center, Indianapolis, Indiana, April 7, and the same lecture at a meeting of the Passaic County Medical Society, Paterson, New Jersey, on April 20
Dr C P Rhoads, director of Memorial Hospital,

New York City, at the session of the American College of Physicians, San Francisco, California, April 21 Dr Marvin R Thompson, professor of pharmacology and therapeutics, University of Maryland, on "Nutrition in Relation to Disease" at homogeneous Location of Maryland, on "Substitution of Maryland, on "Nutrition in Relation to Disease" as the maugural address, Institute of Metabolism and Nutrition, Doctors Hospital, Queens, April 14.



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Procaine Penicillin G in Oil Squibb may be used the same as penicillin in oil and wax in the treatment of in fections due to penicillin susceptible organisms. It is available in 10 cc. vials and in 1 cc. double-cell cart ridges with B D* disposable syringe Each cc. contains 300 000 units of Squibb Crystalline Penicillin G combined with 125 mg of the procaine base in refined peanut oil, with an added dispersing agent.

Average adult daily dose 1 cc. (300 000 units) intramus cularly in severe infections, 300 000 units ever, 12 hours.

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HOSPITAL NEWS

Hospital Convention Scheduled for September

THE FIFTIETH anniversary convention of the American Hospital Association is to be held in Atlantic City, New Jersey, September 20 through September 23, according to a recent announcement The theme of the convention is "Hospitals-Vital

to Better Living"

The morning sessions will be joint meetings of the Assembly and the House of Delegates, with the latter serving as a large discussion panel These the latter serving as a large discussion panel will be devoted to important issues and problems involved in two main areas the care of the patient and hospital finances The Association's president,

Graham L Davis, will preside at the convention The afternoon sessions will be large general meetings, each with two speakers representative of various phases of community life, such as education, science and research, finance, business and industry, public health and government, the individual and the phase of common interest in national defense These speakers will visualize how the hospital has worked to affect their particular phase of community life and to construct what they believe is the future challenge for hospitals and health in their particular

Hospital Planning to Consider Accident Cases

POINTING out the fact that medical expenses resulting from accidents represent about 6 per cent of the nation's total medical care bill of over 6 billion dollars a year, the Hospital Council of Greater New York has stated in the Council's recent Bulletin that "diseases and injuries due to accidents should be considered in hospital planning

"The influence of accidents on the need for and use of special hospital services and facilities is varied and extensive depending on such factors as the type of injury, the nature of the accident, and the age and sex of the individual concerned," the

Bullelin said

Appreciation of these factors will guide the development of facilities to allow for maximum flexibility and service, the Council pointed out alysis of local factors will reveal the particular problem and suggest the solution The same general over-all principles of sound planning apply to each problem and will assure the residents of each community as well as business and industry that their hospital needs will be met in the most economic manner"

The Council's review showed that of the 32,000 deaths from motor vehicle accidents throughout the country in 1947, approximately two-thirds occurred in rural areas, and one-third in cities and towns "On the other hand," the Bulletin continued, "pedestrian traffic accident facilities are more numerous in urban than in rural areas"

Pedestrian accidents resulting in death reached a peak each day between the hours of 6 00 and 8 00 PM, the period of the day when the degree of day light varies with the season of the year, the Council reported Of all pedestrians involved in accidents resulting in death each year during these hours, "58 per cent were killed during the three winter months of November, December, and January It may be expected that emergency room treatment for the injuries sustained in pedestrian accidents will be heaviest at these times"

Approximately one-third of the pedestrian deaths in New York City in 1946 were among individuals 65 years of age and over "It is important to note," the Council stated, "that about 30 per cent of ac cidental deaths of all types involve persons in this Sixteen per cent of the accidental deaths from motor vehicles, 20 per cent of the fatal burns, and 65 per cent of falls which caused deaths were

among individuals in this category "

"These facts emphasize the great need for general care hospital services and facilities for the aged Many of these older members of our communities people are suffering from long-term illnesses or other conditions which may account in part for the high accident rate in this group"

Committee on Hospital Careers Formed

FORMATION of a Citizens' Committee on Hospital Careers was announced in April by Murray Sargent, president of the Greater New York Hospital Association, representing 97 voluntary nonprofit and 22 municipal hospitals in the Greater New York area Mayor William O'Dwyer, as honorary chairman, Miss Helen Hayes, as chairman, and Mr Anson C Lowitz, vice-president of J Walter Thompson Co, as vice-chairman, head the list of prominent citizens and representatives of health, hospital, and welfare agencies who pledged their support, Mr Sargent said
On May 1, the Citizens' Committee of the

Greater New York Hospital Association began a local educational campaign in collaboration with the national campaign of the American Hospital Association and the Advertising Council, to inform the public of the importance of the hospitals as an association for the importance of the impo essential factor in community life and to enhance the prestige of hospital careers for those seeking satisfaction" in employment Special empl was placed on the recruitment of 1,400 student nurses for 34 registered nurses nurses for 34 registered nursing and 5 practical nursing schools affiliated with member hospitals of the greater New York Hospital Association

[Continued on page 1190]



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[Continued from page 1188]

Dean McEwen Stresses Graduate Courses

STRESSING the importance of facilities for the continuing education of the practicing physician, Dean Currier McEwen, of the New York University of Medicine, outlined the College's role in graduate courses in a recent issue of the Journal of the American Medical Association

can Medical Association

"We will agree, certainly, that the function of the undergraduate period of training is to provide a general background of medical education," he says, "and that specialty belongs to the graduate period We all believe, I am sure, that the best way to train specialists is through properly organized residencies,

preferably in hospitals affiliated with medical schools, and that fellowships provide an excellent opportunity for experience in research and teaching We will agree too, that the medical colleges share with the medical societies an important responsibility for the continuing education of physicians"

ity for the continuing education of physicians"
The College's program today, he said, can be divided into (1) Graduate instruction, (2) the regional hospital plan, (3) postgraduate instruction

gional hospital plan, (3) postgraduate instruction Dean McEwen said the present expanded program of formal graduate courses at the College commenced in 1945

NEWS NOTES

Dr Joseph Felsen spoke on "Infectious Diarrheas of Infancy" at the monthly clinical meeting of the pediatric department of Morrisania City Hospital, the Bronx, on May 3

An open forum on "The Acute Surgical Abdomen" will be held on June 13, from 10 00 a m until 1 00 p m, at St Catherine's Hospital, Brooklyn The forum concludes the seventeen-week course consisting of "Surgical Seminars, Demonstration and Practical Application of Surgical Technic" Speakers will be Drs Harry Feldman, Charles A Gordon, Martin A Murphey, J Philip Lombard, and John J Taormina

Dr J P Greenhill spoke on "Progress in Obstetrics and Gynecology" at Lebanon Hospital, the Bronx, on May 3 This was the hospital's Samuel and Minnie Goodfriend Memorial Lecture

All-day sessions on "Trends in Maternity and New-Born Care" were held at Kings County Hospital, Brooklyn, on April 27 and 28

The Clinical Society of the Unity Hospital, Brooklyn, met on April 21 Case reports were given by Drs Mortimer A Rosenfeld, Samuel J Blumenthal, Harry Apfel, and A. Robert Peskin

Guest speakers to the staff of the Veterans Hospital, Bath, in March, were Dr Wallace Hamby, professor of neurology and neurosurgery, University of Buffalo, Dr J Murray Steele, director of research, Goldwater Memorial Hospital, Welfare Island, New York City, and Dr S H Polayes, director of laboratories, Cumberland Hospital, Brooklyn Dr Hamby spoke on "Subarachnoid Hemorrhage and Intracranial Aneurysm" Dr Steele's subject was "Arteriosclerosis," and Dr Polayes' subject was "Isoimmunization with A and B Factors"

A total of 3,171 patients were cared for at the Alice Hyde Hospital, Malone, during the past year, according to the report of the hospital's treasurer, Claude Clark, Jr Averaging nine days per person, the total days of care were 27,138

"Amino Acids" will be the subject of Dr Donald D Van Slyke, member of the Rockefeller Institute of Medical Research, New York City, at a lecture at the US Veterans Hospital, Manhattan Beach, Brooklyn, on May 26 The meeting will begin at 4 00 p m.

New modernized units were opened at the Lutheran Hospital in Brooklyn in March and April, according to O E Schneidenbach, director of the hospital In 1947, 4,242 patients received an average of approximately five and two-thirds days treatment per person at the hospital Surgical operations rose from 1,040 in 1946 to 1,345 in 1947

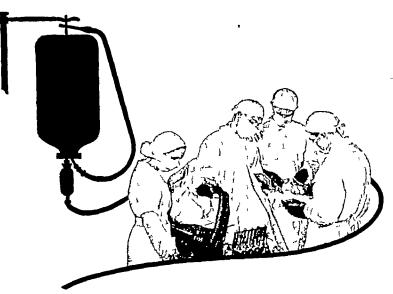
The obstetrical and gynecological services of Beth Israel Hospital, New York City, have been merged, according to an announcement by Dr Maxwell S Frank, director of the hospital Dr Henry C Falk is director of the new service

Dr Michael Heidelberger, professor of biochemistry at the College of Physicians and Surgeons, Columbia University, and chemist to the Presbyterian Hospital, New York City, delivered the sixth Bela Schick Lecture at Mount Sinai Hospital, New York City, on May 11 His subject was "Immunity in Children and Adults as Indicated by the Formation of Antibodies"

Pamphlets describing the need for adequate hospital facilities in Seneca County and how a new hospital may be built with State and federal aid have been issued recently by the Seneca County Citizen's Hospital Committee, according to the chairman, George Glanville, of Seneca Falls

The medical staff of Meyer Memorial Hospital, Buffalo, has approved the establishment of a cancer detection center at the hospital under the supervision of its tumor committee Plans for the center were outlined at a recent staff meeting by Dr Elmer Friedland, secretary of the medical staff

[Continued on page 1194]



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NECROLOGY

Boleslaw M Bukowski, M.D, Buffalo, died on March 24 at the age of fifty-four A graduate of the University of Buffalo School of Medicine in 1916, Dr Bukowski interned at Children s, Mercy, and Deaconess hospitals in Buffalo During World World Research at the Medical Communications. War I he served in the Medical Corps in Europe and was in Germany with the Army of Occupation He was a member of the Eric County and New York State Medical Societies, the Academy of Medicine, the American Medical Association, and the Medical Arts Club

Arthur A. de Grandpre, M D, seventy-seven, of Plattsburg, died on March 13 He was graduated from the Medical School of Laval University, now the University of Montreal, in 1895 Dr de Grandpre began his medical practice at Peru in 1895, moving to Plattsburg in 1908 For many years he was on the staff of the Champlain Valley Hospital there He was a member of the Clinton County and New York State Medical Societies and

the American Medical Association

Nicholas Dobkin, M D, of Brooklyn, died on April 23 at the age of seventy-three A retired physician who had specialized in gastroenterology, Dr Dobkin had practiced in Brooklyn for fortyeven years He was graduated from Columbia University, College of Physicians and Surgeons, in From 1918 to 1927, Dr Dobkin was assistant professor of medicine and chief of the department of stomach and intestinal diseases at the New York Post-Graduate Medical School and Hospital He was consultant in gastroenterology at the Jewish Hospital of Brooklyn Dr Dobkin served in the Army Medical Corps during the first World War and was later a major in the Medical Officers Reserve Corps

He was a member of the New York State and Kings County Medical Societies, the American Medical Association, and the Association of Military Surgeons of the United States

Frank Judson Edgett, MD, of Amityville, died on February 26 He was sixty-one years of age Dr Edgett was graduated from the University of Maryland School of Medicine in 1912 and the New York Homeopathic College in 1916 He joined the staff of the Brunswick Home, in Amityville, more than thirty years ago, later opening a private prac-tice there Dr Edgett had been health officer of Amityville since 1920 He was a member of the Suffolk County Medical Society, the Alumni Association of New York Medical College, the American Medical Association, and the Medical Society of the State of New York

Jacob Julius Epstein, M D, of New York City, died on March 24 at the age of sixty-eight He was graduated from the Yale University Medical School Dr Epstein was on the staffs of Beth Israel and Stuyvesant Polyclinic hospitals until his retirement about ten years ago He was a member of the New York State and County Medical Societies, and the American Medical Association

George Clifford Gould, MD, of Mount Vernon, died on March 26 He was sixty-nine years of age A graduate of Columbia University, College of Physicians and Surgeons, in 1903, Dr Gould began general practice in White Lake after postgraduate studies, moving to Mount Vernon in 1910 thirty-one years, he was head of the ophthalmology division at Mount Vernon Hospital He was also clinical assistant at the Manhattan Eye, Lar and Throat Hospital and a surgeon on its staff until Dr Gould was a fellow of the American College of Surgeons and a member of the New York State, Westchester County, and the Mount Vernon Medical Societies, and the American Medical Association

Howard Hogan, M D, formerly of Nepera Park and New York City, died on April 20 in Dallas, Texas He was forty-eight years of age Dr Hogan was graduated from the University of Edinburgh Medical College in 1933 and interned at Bellevue and Presbyterian Hospitals in New York City and United Hospital at Port Chester He was a member of the New York State and County Medical Societies, the American Medical Association, and the American Anesthetists Association He was formerly medical director of the Nepera Chemical Company, Inc.

William Norris Hubbard, M.D., of New York City, died on April 21 at the age of eighty-seven Dr Hubbard had practiced medicine in New York for sixty years. In 1886 he was graduated from Columbia University, College of Physicians and Surgeons, and joined the staff of Bellevue Hospital, serving as house physician, assistant physician in charge of diseases of the skin, attending physician in general medicine, and head of the outpatient climic there. He joined Polyclime Hospital and Medical School in 1887 as an instructor and lecturer For fifty-five years he was a surgeon at the Manhattan Eye, Ear and Throat Hospital Dr Hubbard was a member of the Academy of Medicine, the New York State and County Medical Societies, and the Bellevue Alumni Society

William Howard Kingston, MD, sixty-seven, of Moira, died on April 17 A graduate of the Long Island College of Medicine in 1909, Dr Kingston began his medical practice in Hogansburgh, moving later to Farmingdale, Long Island He was a former supervisor of the Town of Bombay and was health officer of Bombay and Moira Dr Kingston was a member of the New York State and Franklin County Medical Societies and the American Medical

Association

Tiffany Lawyer, M D, Albany, died on April 12 at the age of sixty-four A general practitioner for forty years, Dr Lawyer was a member of the staff of Albany Hospital He was graduated from the Albany Medical College in 1907 Dr Lawyer was a member of the American Medical Association and the New York State and Albany County Medical Societics

John Stoddard McCormick, M.D., of Albany, ty-eight, died on April 22 Dr McCormick was fifty-eight, died on April 22 Dr McCormick was staff surgeon of St Peter's Hospital, Albany, and for the New York Central System in Albany He was also medical director and surgeon for the Tobin Packing Company Graduating from the Albany School of Pharmacy and Albany Medical College in 1914, Dr McCormick served his internship at Albany Hospital and did postgraduate work at Metropolitan Hospital and Post-Graduate Hospital, both in New York City and in Hospital, both in New York City, and in Vienna He was a fellow of the American College of Surgeons and a member of the American Medical Association, and the New York State and Albany County Medical Societies

[Continued on page 1194]

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[Continued from page 1192]

Lilian Morgans, M D, of Middletown, died on April 7 She was seventy-six years of age Graduated from the New York Medical College for Women in 1906, Dr Morgans served as superintendent of Thrall Hospital in Middletown, and was later consulting cardiologist on the staff of the Horton Memorial Hospital there—She also was associated later with the Lying-In Hospital, New York City, the Mayo Clinic, Rochester, Minnesota, and the Laboratory of Surgical Technique, Chicago—Dr Morgans was the founder of the Middletown Radium Society—She was a member of the American Heart Society, the American Medical Association, the New York State Homeopathic Society, and the State and Orange County Medical Societies

Francis Lansing Stebbins, M D, of Geneva, died on March 27 He was eighty-one years of age and the last of six charter members of the staff of Geneva General Hospital He was a graduate of New York University College of Medicine, in 1891, and a member of the New York State and Ontario County

Medical Societies

1194

Leigh Arthur Simpson, M D, fifty-three, of Fulton, died on March 26 He was graduated from Syracuse University College of Medicine in 1920 and then established a practice in Fulton, serving at different times as city health officer and physician

He was on the staff of Lee Memorial Hospital Dr Simpson was president of the Medical Alumni Association of Syracuse University He was also a member of the Oswego County and New York State Medical Societies and the Fulton Academy of Medicine

Michael A. Sullivan, M D, of Lackawanna, died on March 11 He was seventy-one years of age In 1898 he was graduated from the University of Niagara Medical School Dr Sullivan was on the staffs of the Mercy Hospital, Buffalo, and Our Lady of Victory Hospital, Lackawanna He was a fellow of the American College of Surgeons and a member of the New York State and Eric County Medical Societies and the Buffalo Academy of Medicine

James Benjamin Woodruff, M.D., sixty-seven, of Rochester, died on April 11. A rheumatic fever specialist, Dr. Woodruff was chairman in the Rochester area of the Masonic Foundation for Medical Research and Human Welfare. He was a staff physician at Park Avenue Hospital, Rochester, and a member of the American Medical Association, the New York State and Monroe County Medical Societies, and the Academy of Medicine Dr. Woodruff was graduated from Syracuse University College of Medicine in 1905

HOSPITAL NEWS

[Continued from page 1190]

According to a report from Municipal Hospital, Niagara Falls, there were 95 patients treated at the hospital during the past year, receiving 3,842 days of treatment

Dr Nils Bror Hersloff, who has been chief of the Neuropsy chiatric Division of the Veterans Administration Medical Service in New York since January, 1947, has been appointed manager of the Veterans Hospital in Canandaigua. He will succeed Dr Hans Hansen, who has retired

A World War II veteran with 18 years' experience as a practicing psychiatrist, Dr. Hersloff was graduated from Columbia University, College of Physicians and Surgeons, in 1930, and then took postgraduate training at the Wagner Juaregg Clinic in Vienna. He entered private practice in 1932, was instructor in clinical psychiatry at Columbia from 1933 to 1936, attending psychiatrist at the New York Psychiatric Institute, and chief of the psychiatric clinic at Lenov Hill Hospital from 1934 to 1940





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TO THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

Announce Plans for A M A Auxiliary Meeting

THE twenty-fifth annual meeting of the Woman's Auxiliary to the American Medical Association will be held in Chicago from June 21 to 25, with headquarters at the Hotel LaSalle Auxiliary members or guests of physicians attending the A.M A convention are invited to participate in all social functions and attend the sessions of the Auxiliary

Program for the Auxiliary convention includes June 21—committee meetings, tea in honor of Mrs Eustace A Allen, president, and Mrs Luther H Kice, president-elect, June 22—formal opening of the annual meeting, with an address of welcome by Mrs John Soukup, past president, Woman's Auxiliary to the Illinois State Medical Society, luncheon in honor of the past presidents of the Auxiliary to the A M A, at which Dr Morris Fishbein, editor of Journal of the American Medical Association and Hygeia, will speak

At the afternoon session on June 22, reports will be given by the chairmen of standing committees,

the historian, the central office, and the nominating committee A round table discussion will be held on Hygera, legislation, program, and public relations, with Mrs Arthur I Edison, Mrs Bruce Schaefer, Mrs Ralph Eusden, and Mrs Harold F Wahlquist participating

Reports of state presidents will be presented at the Wednesday session on June 23, and the annual luncheon will be held in honor of Mrs Allen, retiring president, and Mrs Kice, incoming president. The election of officers and formal installation will feature the afternoon meeting, when Mrs Kice, a member of the New York Auxiliary, will give her inaugural address

On Thursday, June 24, a meeting of the board of directors, with Mrs Kice presiding, will be held, and that night the annual dinner of the Woman's Auxliary for members, husbands, and guests will take place The closing day, Friday, June 25, will be devoted to inspection of exhibits

COUNTY NEWS

Albany County

The annual Silver Tea for the benefit of the Red Cross was held on March 31 at the home of Mrs Emerson Crosby Kelly, Albany On April 20, the tenth anniversary birthday party of the Woman's Auxiliary to the Albany County Medical Society was held at the Albany Country Club

Lewis County

Sponsored by the Woman's Auxiliary of the Lewis County Medical Society, senior high school girls from Beaver Falls, Lyons Falls, Port Leyden, and Lowville met recently at the Lowville Academy to hear a talk by Miss May Chitwood, district superintendent from Gouverneur, on nursing and nurse training

On March 3, members of the Auvaliary met to cut and sew hospital supplies

Livingston County

Plans for a series of benefit card socials, the first held on April 22, were made at a dinner meeting of the executive board of the Livingston County Auxiliary, at the home of Mrs Willard Hall Veeder, Sonvea, president.

Mrs Harry Norton, Rochester, seventh district councillor, was guest of honor and speaker at a luncheon meeting on April 7 at the Avon Inn, Avon Mrs Norton urged support for the nursing scholarships and for the Physicians' Home Mrs Charles Newton, Geneseo, vice-president, presided at this meeting

Members of the Livingston County Auxiliary are now making afghans for the Physicians' Home

Nassau County

April activities of the Nassau County Auxhary included a Scholarship Bridge on April 21 at the Garden City Hotel, for which Mrs George Christmann was ticket chairman, and the regular monthly meeting on April 27 at the Nassau Hospital auditorium Mrs Nathaniel Robin, chairman of the mental hygiene committee, discussed the report of the Nassau County Mental Hygiene Preparatory Commission for the International Congress on Mental Health

Oswego County

Mr Joseph Chrabecz spoke on "Interior Decorations" at the April 16 meeting of the Oswego County Auxiliary, for which Mrs. C. K. Elder was hostess

The annual dinner dance for doctors and their wives was held May 6 at the Pontiac Hotel, Oswego Chairman of the committee was Mrs. K. M. Jarvis

Queens County

Mrs Ida Philip, New York City, spoke on "Alcoholics Anonymous" at the April 27 meeting of the Queens County Auxiliary, held at the Medical Society building

Proceeds from an amateur variety show, scheduled for May 15, will be used to purchase items for the children's wards of each of the voluntary hospitals. Cast of the show includes members of the Medical Society and their families. Mrs. Ezra Wolff is chairman, assisted by Mrs. Sol Axelrod.

man, assisted by Mrs Sol Axelrod
"Floral Decorations" will be the topic for the
May meeting, to be held May 25 at the Medical So-

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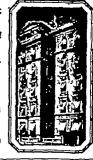
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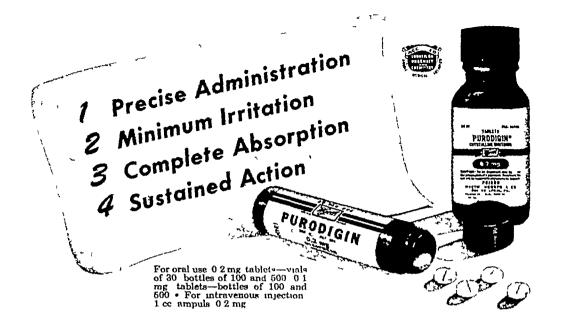
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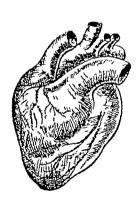
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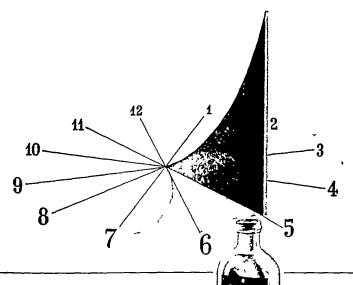
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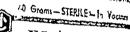




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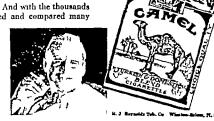
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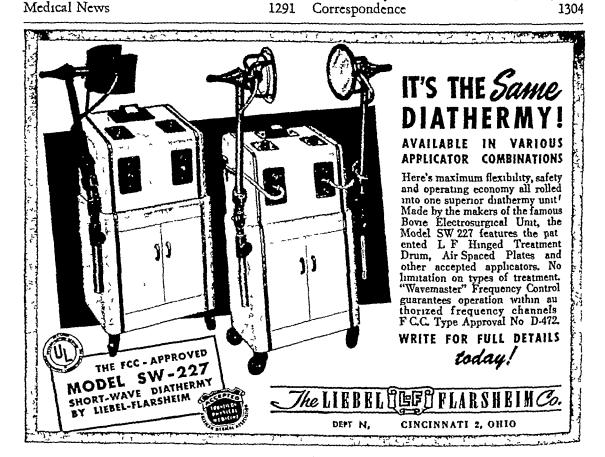
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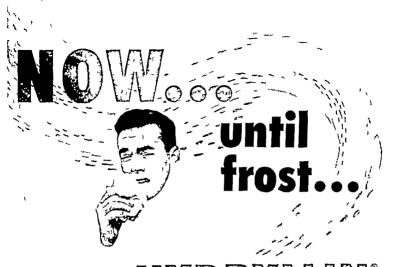
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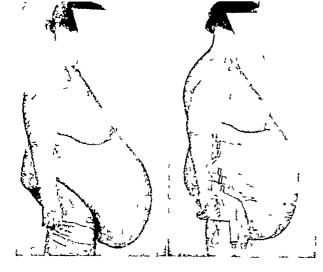
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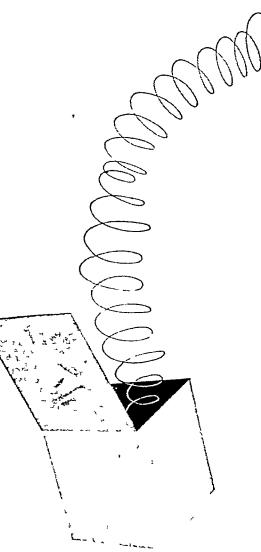
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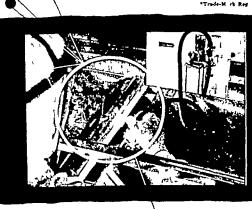
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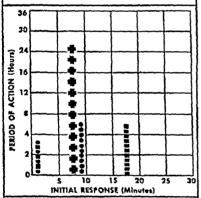
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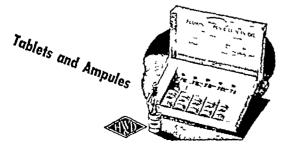
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* Patent applied for



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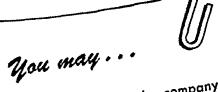


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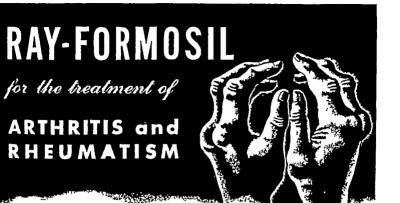
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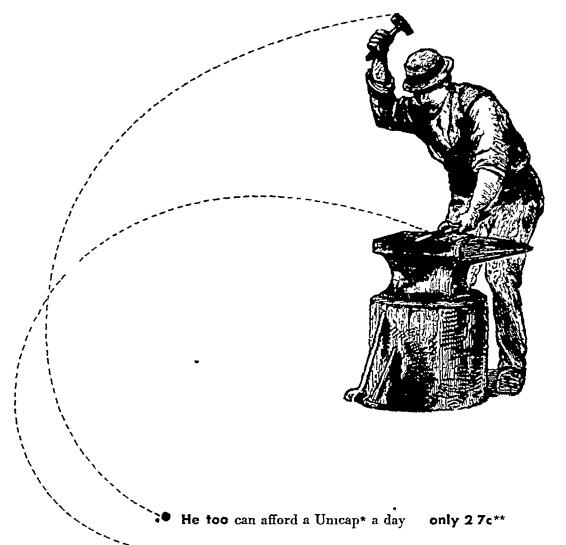
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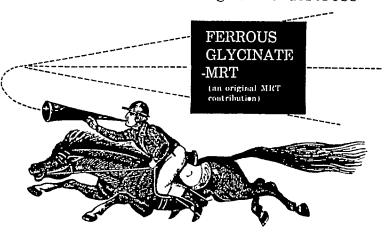
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Shemin D., and Rittenberg D: The Utilization of Glysine for the Synthesis of Porphyrin J Biol. Chem., 189:547 1945

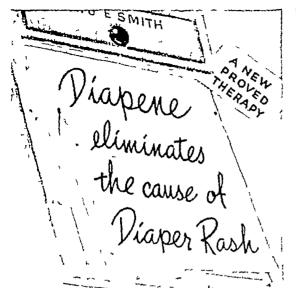
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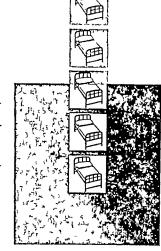
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1 Pieres, R. R.; Am. J. Obet. & Cysec. vol. 55 (F. h.) 1948. #Enchafve trademark. © Schooley Leberatories, Inc.



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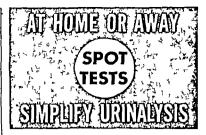
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NEW YORK STATE JOURNAL OF MEDICINE

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Fditorials

A Task for Today

A correspondent writes, relative to the nedical rehabilitation work now going on In the fall of 1917, a captain of my acquainance, in the Royal Army Medical Corps, seemed in perfect physical condition, but us hair and mustache were white. When I nquired how such an old man happened to æ on active service in France, I was told hat his brother had embezzled and lost all us money, and that, perforce, the captain and emerged from retirement and joined the Army When I came to know him better I me day ventured to condole with him on the subject of his misfortune I shall never forget the flash in his eye as he glared down his nose at me

"Hard luck? On the contrary, most

stimulating '

"It was my first encounter with the docirine that it is not what you have lost, but

what you have left, that counts "

The temerity of anyone who dares to strike a note of optimism in this pessimistic era is noteworthy. Yet it undoubtedly happens at times that good cometh out of bad. What we have in mind is the present day attitude toward the crippled, the handicapped, and

those generally regarded, until a short time

ago, as unemployable

Attention has been focused on the handicapped through the medium of the war casualty amputees. An incalculable service to the cause of rehabilitation was rendered recently by a man who had lost both arms. He appeared in a motion picture. Audiences the country over watched him in silent fascination as he reached into his pocket, took a cigaret from a package, tore a match from a packet, struck it, and lit the cigaret.

The moral of the spectacle is that he had attained his skill to please himself. He didn't do it for applause. He didn't do it for money. He did it because he, himself, recognized that he was confronted with an overwhelming handicap. If he didn't overcome it, he would be, for the rest of his life, dependent upon others. If he did overcoment, he would be, for the rest of his life, the recipient of applause. Instead of "Why didn't you do better?" his ears will always hear "Isn't it wonderful that you can do it at all?" Many of us may well find it in our hearts to envy him.

Coming down to the less spectacular, the

war also created a labor shortage ployers became more tolerant of the qualifications of those seeking work They found that all varieties of the handicapped could be employed in one capacity or another provided they wanted to work

We do not subscribe to the doctrine that every human being wants to work ences with the beneficiaries of the Workmen's Compensation Law seem to show this. perhaps regrettably, by the celerity with which some injured working people will adapt themselves to living on a comparative pittance paid them weekly for the privilege of staving sick

But the average compensation case is not necessarily comparable to that of the unemployable person The latter is tired of sitting around, tired of being a dependent, tired of saying, "Thank you" He is a person confronted with a handicap and challenged by it to prove himself a man gets a 10b, he does not keep it because he is grateful to his broad-minded, charitable, humane employer He keeps his 10b to prove to himself his manhood He exercises care over the ordinary things that the normal man neglects He is not late. He is not absent He realizes that, no matter of what he has been deprived, his remaining abilities have been thereby sharpened He pays unremitting attention to his job because he is paid for it, and that fact stimulates his pride He knows he can compete on equal terms with so-called normal men and women, provided his employer has found him a job for which he is fitted

From these general statements we descend to statistics 1

Disabled More efficient than the able-bod-		
ıed	7	%
As efficient	87	2%
Less efficient	5	%
Disabled, absent		
Less than the able-bodied	49	%

Department of Labor, Bureau of Labor Statistics, Impaired Workers in Industry" Monthly Labor Review (Oct.) 1944

As often	43 8%
More often	7 2%
Disabled, injured	, -
Less than the able-bodied	51 1%
As frequently	37 7%
More frequently	11 2%

Possibly this country needs, more than anything else today, a lively sense of community solidarity Are we to have war again? Is the atom bomb to fall somewhere? There is little that the average man can do about that But in the days, months, or years that remain to us as a span of time worth living there is a great deal we can do

The doctor can be mindful of his obligation to treat the whole patient He will not wash his hands of his responsibilities toward him the day he leaves the hospital

Labor unions and employers can work together toward the goal of full employment. to their mutual benefit, and insurance companies can be persuaded to insure the handicapped

Our Woman's Auxiliary, and every women's organization in every town in the State, with their facilities for intimate knowledge of community conditions (call it gossip, if you like) could find where needs exist, and ferret out means for meeting them. Taxpayers will be relieved of a heavy obligation, and the morale of the community will This is certainly an activity to counter the effects of too much reading of the newspapers and too frequent listening to radios blaring of a possible world catastrophe to

So far, there are few rehabilitation centers in this State, that at New York University and Bellevue Hospital being the most active Others are sure to come, however, far more important than buildings is the implantation and encouragement of the idea of rehabilitation in every community in New York State

Entron's Norm The following references will serve as useful guides for those interested

Rehabilitation. York University, Washington New Square 3, New York City
New York Times Magazine (Jan. 27) 1948

Ibid. (May 12) 1946 Ibid. (June 23) 1946

Editorial, New York Times (Feb. 20) 1948.

A Valuable Suggestion

We are in receipt of a communication of considerable ment from a valued correspondent which we take the liberty of quoting nearly in full

I wish to call your attention to a situation which has given me considerable anxiety, namely, your reference to "Organized Medicine" As a doctor interested in my profession, I understand the genesis of that term and what it wishes to convey However, it is a term that is quite ambiguous and potentially may be harmful for the profession from a sociologic viewpoint. Some of my friends who are professional people and successful businessmen, interested in the social aspects of medicine, have spoken to me about it they pointed out the fact that engineers refer to the engineering profession, lawyers refer to the legal profession, and teachers to the teaching profession, whenever they discuss their profession as such.

However doctors speak of "Organised Medicine' when they wish to refer to the medical
profession. It conveys at times a meaning far
from what it is intended to be The lay person
thinks of the expression "organised" as an organ
ization for the purpose of furthering the interests,
generally economic, of the members of a particular
organization, as a labor union etc. They therefore associate the expression "Organized Medicine' as consisting of doctors primarily organized
for the purpose of furthering their own personal
and economic conditions, and they, therefore
react to that expression with hostility, conscious
or unconscious. Wouldn't it be advisable here-

after to change the term "Organized Medicine" to "Medical Profession"?

1243

We think this suggestion so valuable, as a means of improving public understanding, that in the future no use will be made of the term "Organized Medicine" in our editorial columns. We urge that others who agree with us adopt the term "Medical Profession" as standard usage

We also offer the suggestion that editorial writers and speakers on medical subjects discard other terms which in our opinion do not convey, at least in modern times, an accurate impression. One hears doctors speaking of the public as "the laity." This is a holdover from a time when medicine was practiced by ecclesiastic practitioners and at that time could properly be used. However, in these days the expression is inaccurate and by implication attributes to the medical profession a status which it no longer occupies, except perhaps in a few instances.

Many more archaic expressions could be found, with some research, without which medical writers and speakers would be no whit hampered in writing or speaking and which they use rather thoughtlessly with little regard to the accuracy of the meaning in modern times. However, we content ourselves with these two, believing that if we can accomplish that much, something will have been done

Current Editorial Comment

Exploitation —More doctors smoke cigarets than any other brand

The soap preferred by leading dermatologists is

And in such vein the radio commercials day after day carry on their hullabaloo JTW, writing in *The Saturday Review of Literature*, blasts editorially against what he terms "The calculated exploitation of an entire profession" His point is well taken as the excerpt below indicates

"Most doctors," the radio blares, trying to sell something or other (and the radio isn't peddling stethoscopes), "seven out of ten Hollywood stars' drink or amoke or wash their faces with such-and-such "your dantist uses whatnot" (we asked ours, and he didn't) When is most? Seven out of ten is a clear-cut ratio, but how many tens were consulted, and who determines what a Hollywood star is? Don't doctors ever raise a voice in protest against the calculated exploitation of an entire profession? Are they always going to take it, like their patients, lying down?

The editorial was written some time ago But protest as far as we know has been lacking or is at best extremely faint. The "calculated exploitation" continues, as anyone can verify by listening. We urge our membership to inform themselves of the

^{1 (}Dec. 23) 1946, p. 20.

extent to which this is being done by listening to the various programs

The medical profession has something—the confidence of the people. This has been acquired over long years by the maintenance of high standards of education and practice, based on sound scientific research. Subtly, that confidence is being commercially exploited and probably always will be to some degree. The extent to which it is exploited is possibly a rough measure of the esteem in which the medical profession is held by the public, or the radio sponsor's estimate of that esteem, and in a sense complimentary. Maybe this would account for the lack of protest.

JTW also exconates the loose use of vague authorities "people say," "Washington seems to believe," "It is considered significant", also the person who, when interviewed, many times "yielded to the glorious opportunity to become a spokesman, an interpreter, a know-it-all, and had the complete, pat answer — Invariably, of course, he simply told what he thought" He warns further against the speaker who has the effrontery "to think for his audiences—'I know that most of my listeners will agree with me,' or 'The American business man appreciates too well,'" for examples

There may be nothing particularly insidious in all this And again there may be The average intelligent listener or reader, one hopes (or do we statistically presume?), is capable of discounting, and does discount, at least the more flagrant numerical attributions and generalizations are the product of sheer laziness, as much physical as intellectual It is so much easier to write a think-piece, so much simpler to interpret "local opinion," or to lean back on dat ole debbil Consensus, without putting oneself to all the hard work of rounding up substantial and provable facts The handout is partly (proportion undetermined) to blame Time was when a reporter had to use his feet as well as his head, too often today the mimeograph machine makes it unnecessary for him to overevert either end

Everyone has a right to his own opinions—and a right to no one else's

Pelvic Cancer Attention may well be drawn to a stimulating and informative article by Dr Norman F Miller on this subject which appeared in a recent issue

of the Journal of the American Medical Association 1 In plain and simple language he shows that the pessimistic attitude toward cancer, both by physicians and the general public, is quite unjustified tunately, most cancers are first seen in an advanced stage when the question of "cure" naturally is problematical useless to wait for a new "cure", to do so is faulty reasoning and, as Miller well states, is one key to the present difficulty Much can be done with the diagnostic and therapeutic tools now at hand, although thus far these are largely limited to surgery and irradiation Prevention and early treatment must remain the keystone of the

arch for handling the problem

Undoubtedly there is a great waste of time involved, for patients are either unaware of or mattentive to early symptoms, or the doctor fails to pay attention to complaints that are often indefinite. It would be desirable if careful periodic examinations of all women could be developed, women especially of forty and over, for women constatute the largest quota of susceptible individuals Moreover, periodic examinations may be necessary twice, rather than once, a year These need not be expensive or time consuming, but proper qualifications of the examiner are essential, and the methods are readily and easily acquired As the author quotes in his article, "healthy patients* are frequently embarrassed, discouraged, and commonly dissatisfied by the unresponsive attitude manifested by the physician" We might interpolate here that this is what often drives them to public detection clinics—and there they are lost as private patients However, the propaganda, both good and bad, has resulted in a cancer awareness on the part of the public which must be met and satisfied general practitioner, according to Dr Miller, plays the key role, and with this we agree The problem is not insurmountable, but it is important enough to present a vast challenge to the medical profession

The Council Committee on Health and Education, through its Subcommittee on Cancer, has afforded opportunity for physicians to make themselves acquainted with the means for obtaining the necessary information about cancer activities. Let it be consulted when needed

Vol. 136, No 3 (Jan. 17) 1948
 * Apparently healthy?—Ep

Scientific Articles

PENICILLIN TREATMENT OF EARLY CONGENITAL SYPHILIS

Dabney Moon Adams M D and Charlotte Marker, M.D., New York City

(From the Department of Pediatrics New York University and the Children's Medical Service Bellevue Hospital)

OVER A period of four years from 1943 to 1947, 69 cases of infantile congenital syphilis were treated with pencillin on the pediatric cervice of Bellevue Hospital Of this number, 26 were infants of less than three months 18 were between three months and ax months old, 10 were between ax months and one year and 15 were between one and three years of ago Chil dren over three years of age are omitted from this study, as the follow-up period was considered too short to evaluate their seriologic response

In the case of young infants less than four months of age, the diagnosis of syphilis was not based on positive serology alone but was confirmed by definite roentgenologic evidence of syphilitic involvement of the long bones or clinical evidence of syphilis, thus excluding nonsyphilitic patients whose positive serology represented the reagin in the mother's blood

Clinical Findings

Table 1 shows the clinical manifestations of Typhilis on admission The roentgenologic find ings of "advanced" changes in the long bones consisted of marked areas of destruction of the shaft and marked periostitis ' moderate changes consisted of periostitis and areas of rarefaction in the shaft, and "slight" changes comprised only widening of the epiphyseal line and distinct periostitis. Lymphadenopathy in the axillary epitrochlear or posterior cervical regions was considered evidence of syphilis when no other cause for glandular enlargement could be ascertained. Enlargement of inguinal or anterior cervical glands alone was not considered evidence of syphilis. Dark field examinations from the cutaneous lessons were positive in seven cases,

In the 26 infants less than three months of age the most frequent findings were syphilitic involvement of the long bones present in 78 per cent, nuccoutaneous lesions in 50 per cent, snuffles in 30.8 per cent, along an in 80.8 per cent, edema in 20.5 per cent enlarged liver in 19 per cent, aden opathy in 15 per cent, prematurity in 15 per cent, and preceduloparalysis in 11 per cent, and bloody diarribea in 11 per cent. Twenty-six and five-tentis

TABLE 1.—CLINICAL MANIFESTATIONS OF STRIILIS

		1 (
Manifestations	Under	- Age C	6 Months	I to 3
of Syphilis	3 Months	Months	to I Year	Years
Positive serology				
only		1	2	5
Muoocutaneous le-	13	ě	4	ă
aions				
§nuffles .	8	11		
Osseous lesions				
Moderate		4	_	
Advanced	18*	6 2 2	а	
Pseudoparalysis Daetylitia	9	- 2		
Prematurity	3 I 4 8	2		
Anemia		13	8	6
Edema	•	10	۰	10
All extremities	2			
Berotum	231145728	1		
Eyelida	1	7		
Boles	1			
Lymphadenopathy	4	4	п	
Enlarged liver	5	5	6	1
Paipable spleen	7	7	6	i
Jaundice	2	5 7 1		
Bloody stools Involvement of	8	1		
finger nails	1			
Alopecia eyebtowa	•			
and scalp		2		
Central nervous		-		
ayatem				
Berologio	6	1		
Serologic and				
clinical	1			
Total number of				
cases in each age			••	
group	26	18	10	12

^{*} In two cases roentgenograms were not taken

per cent of this age group had evidence of syphilitic involvement of the central nervous system Of the latter, only one case had clinical signs of central nervous system involvement

In the second age group of 18 infants between the ages of three and ax months, the most frequent clinical findings were anemia, present in 72 per cent, snuffles in 61 per cent, involvement of the long bones in 55 per cent, involvement of the long bones in 55 per cent, involvement of the long bones in 55 per cent, and tymphadesions in 50 per cent enlarged spleen in 38.8 per cent, enlarged liver in 27.8 per cent, and lymphadenopathy in 22 per cent. One infant had a positive spinal fluid Wassermann without clinical evidence of central nervous system involvement. One presented no clinical evidence of syphilis and the diagnosis was made on using positive serologic titer

In 10 infants of the age group between six months and one year, anemia was the most frequent finding being present in 80 per cent of the cases. Lymphadenopath, enlargement of the

liver, and enlargement of the spleen occurred in 60 per cent of the cases Mucocutaneous lesions were present in 40 per cent and involvement of the long bones in 30 per cent. Two cases, 20 per cent of the total, were diagnosed on persistent positive serology of high titer.

In the group of 15 children between one and three years of age, 26 6 per cent of the cases presented no clinical evidence of syphilis and were diagnosed by positive serology and history. Anemia was present in 40 per cent of the cases and mucocutaneous lesions in 20 per cent. Of the latter, one case was a mucocutaneous relapse following treatment with arsenicals and bismuth. There was one case of enlarged spleen and one of enlarged liver. None presented central nervous system involvement.

In Table 2, the treatment of the mother prior to and during pregnancy is summarized in relation to the chinical evidence of syphilis in the offspring. Penicillin has proved to be the most effective drug in the prevention of congenital syphilis. In the report of Speiser et al., for example, on a series of 250 cases of women treated with 1,200,000 to 4,000,000 units of penicillin prior to or during pregnancy, there were only four syphilitic offspring (1 5 per cent), all from the group treated with 1,200,000 units. Nevertheless, it is interesting to note that, in our series, 36 3 per cent of the mothers had received some form of prenatal treatment, and, in 27 per cent of these, penicillin was the drug used

TABLE 2 -- PRENATAL TREATMENT OF MOTHERS OF SYPHI-LITIC INFANTS

LITIC INFANTS				
		Evidence in Offe Positive	of Syphili spring	
Type of Treatment	No of Cases		Clinical Evidenc	
Prior to pregnancy		-		
Penicilim 1,200 000 units	1		1	
Arsenic and heavy metal	4	1	3	
During pregnancy				
Penicillin	•			
4,000,000 units	1		ř	
1,200 000 units * 800,000 units	0		8 1	
** Penicillin and arsenic	1		‡	
Arsenic and heavy metal			1	
1st through 3rd trimester	2		2	
2nd and 3rd trimester	2		ã	
3rd trimester	11	1	10	
Treatment status unknown	6	2	4	
Untreated	87	4	33	
Total	87 69	2 4 8	10 4 33 61	

^{*} Delivered before completion of therapy ** Dosage of penicullin not known.

Treatment

An aqueous solution of penicillin was administered intramuscularly at intervals of three hours. The total dosage, duration of treatment, and schedule of administration varied widely in the cases treated during the first year of the study. For newborn infants the dosage ranged from a minimum of 60,000 units, given over a three-day

period, to 1,000,000 units, given over a ten-day Most of the infants under three months of age treated during the first year of the study received a total dosage of 400,000 units, those from three to six months 600,000 units, those from six months to one year 800,000 units, administered in eight and one-half days. For the infants treated during the latter period of the study, representing the majority of the treated cases, the dosage was based upon weight (Table 3), 100,000 units per Kg of body weight being The method of administration was also changed so that the dosage was graduated, 200 units per Kg were administered every three hours the first day, 400 units per Kg the second and third days, and 800 units per Kg the fourth and The amount then remaining was fifth days given in equal doses every three hours, from the sixth to the fifteenth day No antisyphilitic treatment other than penicillin was administered

Two children, included in this series, had received previous treatment. One, aged fourfeen months, had been previously treated with arsenic and bismuth and presented a chinical relapse with dark-field positive cutaneous lesions. The other, aged ten months, had received irregular and inadequate treatment with bismuth, prior to penicilin therapy. Two other infants, one three months of age, with bloody stools and an enlarged liver, and one with bloody stools and jaundice, died so shortly after penicilin therapy was started that they are not included in this study.

In addition to penicillin, the babies received supportive treatment of every type indicated, including transfusions. Records were kept of the reactions to treatment, differentiated from intercurrent infections developing during the period of hospitalization.

Results

In Table 3, the serologic response to treatment is tabulated for 48 cases adequately followed Twenty-five (52 per cent) were girls, twenty-eight (48 per cent), boys Eleven additional cases were followed inadequately, and no definite conclusions could be drawn as to the serologic results All patients in the latter group, however, showed a consistent drop in titer while under observation Ten children failed to return to the clinic after hospital discharge

In cases listed as showing a "marked drop" in titer (Table 3), the Wassermann reaction was negative or one plus, and the reaction to the precipitation test was a weak positive at the time of their last clinical check-up

It should be noted when interpreting the results of treatment that the penicilin used during the course of this study probably varied considerably

TABLE 3.—RESULTS OF TREATMENT

			Com	piete Be Revers	rologie	Ma	rked D ter Bero —Testa	op in		
Аря Сігопр	Doeage in Units per Kg. Body Weight	Duration of	3 Months After Treatment	3 to 6 Months After Treatment	6 to 15 Months After Treatment	3 Months After Treatment	3 to 6 Months After Treatment	6 to 15 Months After Treatment	Serologic Fallures or Deaths	Number of Cases Pollowed
Under 3 months	Less than 50 000 50,000 to 100,000 100 000 or more	2 to 7 days 4 to 10 days 7 to 15 days	2 5	1 1 3	1	3	1		1	3
3 to 6 pronthe	Lem than 50 000 50,000 to 100,000 100 000 or more	2 to 7 days 7 to 8 days 8 to 15 days	1	1	1 6			2	2	1 10
6 months to 1 year	Loss than 50 000 50,000 to 100 000 100 000 or more	7 days 8 to 15 days			1			,		1
1 to 3 years	Less than 50 000 50,000 to 100 000 100,000 or more	3 to 7 days 7 to 10 days 15 days			1		1	i	1	4 2 1

with respect to such factors as potency and purity 2

Of the 26 infants under three months of age, three received less than 50,000 units of peniculin per hg of body weight Two of these had complete serologic reversals, and one died during treatment Four who received between 50 000 and 100 000 units per Kg of body weight had complete serologic reversals. Of 19 who received 100 000 units or more per Kg of body weight, 12 had complete serologic reversals four had negative Wassermann tests and only slightly positive reactions to precipitation tests, one was a serologic failure, and two died Of the total for this age group, with marked variation in dosage of penicillin, 84 6 per cent showed complete serologic reversal or marked drop in serologic titer 115 per cent died during or after treatment, and one, or 3 per cent, was a serologic failure

In the second age group, from three to six months 13 were followed adequately. Of two infants who received less than 50 000 units of penicillin per Kg of body weight, one was a serologic failure, and one died during treatment. One patient received between 50 000 and 100 000 units of penicillin per Kg of body weight with complete serologic reversal. Ten received 100-000 units or more per Kg of body weight not showed complete serologic reversals or marked drop in titer. Thus complete serologic reversal or marked drop in titer was obtained in 84.6 per cent of the cases. Seven and seven tenths per cent died, and 77 per cent were serologic failures.

Of the infants between six months and one year of age, only two cases were adequately followed. One received between 50 000 and 100 - 000 units per hg of body weight and one 100 - 000 units. Both showed complete serologic reversal

In the one-to three-year group seven cases were

followed Of four children who received less than 50,000 units per Kg of body weight, one showed complete serologic reversal and one a marked drop in titer Two were failures Of two who received from 50,000 to 100,000 units per Kg of body weight, one showed a marked drop in titer, and one was a failure One who received 100 000 units per Kg of body weight showed a marked drop in titer Of these seven children, 57 per cent showed satisfactory serologic response to treatment, and 43 per cent were failures.

Excluding the infants who died during or shortly after therapy, the highest percentage of failures occurred in children between one and three years of age and in those receiving less than 50 000 units of penicillin per Kg of body weight. Of those children who received less than 50,000 units per Kg, satisfactory results were obtained in four cases (57 per cent) and failures in 3 (43 per cent). In the 50 000 to 100 000 group, seven cases (87 per cent) obtained satisfactory results, and one case was a failure. Twenty-eight children (96 per cent) who received 100 000 units per Kg or more were successfully treated, whereas one was a failure

For the total group with all treatment schedules included, satisfactory results occurred in 81 per cent, serologic failures in 10 per cent, and deaths in 9 per cent Of those children who became seronegative, the average time for complete serologic reversal was seven and one-tenth months after penicillin therapy

In the series of 252 cases, reported by Platou et al., the results were similar. Their findings, for all treatment schedules combined, showed a satisfactory outcome in 74 per cent, unsatisfactory in 9 per cent and uncertain in 18 per cent.

Among the nine cases listed in Table 3 as serologic failures or deaths one infant of two months

who had received 100,000 units of penicillin per Kg of body weight showed a moderate drop in serologic titer followed by a rise to a strongly positive reaction, which persisted fifteen months after completion of treatment His spinal fluid Wassermann was positive on admission, but he presented no clinical evidence of central nervous system involvement A failure in the older group is represented by a three-year-old patient who was given 1,200,000 units for a period of seven and a half days His serology showed a drop in titer three months after treatment, followed by a rise and a persistently strong positive reaction eighteen months after treatment remaining three failures were children whose dosage was extremely low One received only 9,500 units per Kg of body weight, the second 12,000 units, and the third 30,000 units per Kg of body weight

The child who received 9,200 units per Kg initially, presented an interesting problem this course of therapy at the age of four months, her titer remained persistently high Five months later, she was retreated with 80,000 units per Kg Since her serology continued essentially unchanged, after six months she was given a third course, consisting of 110,000 units per Kg In the interval between the second and third courses her spinal fluid became positive pletion of the third course, the blood titer increased, and the spinal fluid remained positive Eight months later, a fourth course of treatment, consisting of 4,000,000 units of penicillin (over 400,000 per Kg) was administered over a period of twenty days in conjunction with five injections of triple typhoid vaccine Following this, the spinal fluid became entirely negative, and the serologic titer began to drop slowly Fifteen months after the last course, the quantitative blood Kahn was a weak positive Dunham, Hamre, and Rake have demonstrated in rabbits that Treponema pallidum can become resistant to penicilin, given a dose sufficient to modify the disease but not enough to cure 4 It is possible that this is what occurred in the case described above

Also listed among the failures are four infants who died during treatment, or shortly thereafter, with no improvement of symptoms other than pseudoparalysis and skin lesions. The youngest of these was an infant, eleven days old, whose symptoms were jaundice, malnutrition, bloody stools, and vomiting. She received 5,000 units of penicillin at intervals of three hours, in 27 doses, making a total of 135,000 units. She died before the completion of therapy. The second was an infant seven weeks old who presented anemia, enlarged liver and spleen, and extensive skin lesions, from which a dark-field examination was positive. She had, in addition, edema, snuffles,

albuminuria, diarrhea, and extensive involvement of the long bones This patient completed a course of 100,000 units of penicillin per Kg of body weight, administered over a fifteen-day period Death occurred two days after completion of therapy without improvement in symptoms other than the skin lesions The third infant, aged two months, presented marked jaundice, enlarged liver and spleen, and extensive bone lesions He completed a course of 100,000 units of penicillin per Kg of body weight over a period of fifteen days This child died two days after completion of therapy without showing any chincal improvement The fourth child, five and onehalf months of age, presented a rash, snuffles, pseudoparalysis, enlarged-liver, and adenopathy Her stools were green and watery She received 5,000 units of penicillin at intervals of three hours for 78 doses, making a total of 390,000 units, but died of an intercurrent infection on the twentyninth hospital day

With the exception of these four patients who died during or shortly after completion of therapy, the clinical response to treatment was immediate and striking. Mucocutaneous lesions and snuffles cleared within a few days to a week. There have been no mucocutaneous relapses in the cases followed. Visceral enlargement and adenopathy had involuted at completion of therapy. Healing of syphilitic lesions of the long bones occurred within six weeks to eight months after completion of therapy, the newborn to three-month age group showing more rapid healing that the three to six-month group

During treatment, 15 of the patients developed symptoms which could not be attributed to any cause other than a reaction to therapy. Eleven patients developed an elevation of temperature of 101 to 103 F. In two cases this was persistent, in six, early and transient, and in three, late and transient. Three infants developed urticana, which subsided during therapy, and one developed albuminuma, which cleared promptly upon completion of treatment. In no case was a reaction severe enough to interrupt therapy

In this series, we found that administering pencillin in gradually increasing doses did not sigmificantly affect the incidence of complications following therapy. Other observers have reported similar results in this respect.

Summary and Recommendations

Sixty-nine cases of congenital syphilis in children, ranging in age from newborn to three years, were treated with penicillin. The dosage varied from 9,500 units per Kg of body weight to 100,000 units or more per Kg of body weight. The duration of treatment varied from three to fifteen days.

Clinical evidence of ayphilis was present in 88 6 per cent of these cases. The most common findings in young infants were osseous involvement 78 per cent, mucocutaneous lesions 50 per cent, in older infants, anemia 80 per cent snuffles 61 per cent, and visceral involvement 60 per cent. In 114 per cent there was involvement of the central nervous system. Fifty-three and six tenths per cent of the mothers had received no prenatal treatment, 37 7 per cent were treated prior to or during pregnancy, and in 87 per cent, the treatment status was unknown.

Of 48 cases adequately followed 29 showed complete scrologic reversal within fifteen months, 10 showed a marked drop in titer five were scrologic failures, and four patients died. The average time for complete scrologic reversal after thempy was seven and one-tenth months. Satisfactory results were obtained in 81 per cent, failures in 19 per cent. Optimal results occurred in infants of less than one year.

Omitting the four infants who died during or shortly after treatment, the highest percentage of failures occurred in children between one and three years of age, and those receiving less than 50 000 units of penicillin per Kg of body weight hone of the failures had clinical relapses.

Although the results which have been reported with 50 000 units per Kg of penicillim have been appreciably better than those with smaller amounts, there was still a large enough number of failures to warrant a further increase in dosage. In the light of our present knowledge, it is not yet possible to determine the dosage which will reduce failures to the absolute minimum. Since the introduction of pure penicillin G in the commercial preparations, it should be easier to correlate dosage with maximum therapeutic effect.

As a result of the data available at present, however, we believe it advisable to use at least 100 000 units per Kg of penicillin for congenital syphils. The present practice of dividing the total amount of penicillin into 120 doses, given at three-hour intervals over a period of fifteen days, is probably more effective than large amounts over short periods of time

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GERMAN MEASLES AND PREGNANCY

According to a statement made by the National Society for the Prevention of Bilindness the web of proof that German messles during the first three months of pregnancy may cause congenital malformations is being woven tighter.

In a report by Dr. Herbert C. Miller, University that the state of the state

In a report by Dr. Herbert C. Miller, University of Kansas Hospitals, of 132 mothers who had German measles during the first trimester of pregnancy there were 18 hables reported as normal Sixty two babies weighed less than six pounds at birth. Seventy-six babies had congenital cataracts. Thirty-five were found to be partially or completely deaf. Twenty two babies were microcophalic, and 46 were mentally retarded Malformations of the heart wure diagnosed in 17 babies but none were diagnosed as blue babies. Disturbances of the heart wure diagnosed in 17 babies but none were diagnosed as blue babies. Disturbances of every other than congenital cataracts were observed in 13 babies, including congenital glaucoma three, microphitalmus five nystagmus two chori oretinith two and strabismus two. Dental defects were found in two children, one of whom had congenital absence of some of the teeth and the other of whom had a diffuse enamel defect. Hypospadias was observed in four children and inguinal hernias in four Malformations of the extremities, including club foot one, and webbing of the fingers one were

found in three babies. Cleft palate was diagnosed in three children and harelip in one. Micrognathia was diagnosed in one child. There was one cretin one mongolian idiot, one child with enlargement of one car another with enlargement of one breast one child with a defect of the fourth rib

Other infections than German measles were reported, but the data are too scanty except perhaps in respect to infectious mononucleosis. There have been four mothers who contracted infectious mononucleosis during the first ten weeks of pregnancy, and throe of the four babies had malformations of the heart. Two of the three bables died in the first two weeks, and poetmoriem examination rovealed extensives congenital malformations. One of the three babies with heart trubble had congenital cataracts. No other malformations were found. The fourth baby has remained entirely well.

In order to make this study of increasing significance the committee needs more case material reportally cases of German measles in expectant mothers where the diagnosis has been made by a physician

Doctors who have such information are requested to write to Dr. Herbert C. Miller, University of Kansas Hospitals, Kansas City. Kansas

OBESITY AND HYPERTENSION

Morris B Green, MD, and Max Beckman, MD, New York City

NE OF the common complications of obesity is damage to the cardiovascular system Several factors are responsible, not only the excessive load the heart must bear day in and day Fatty tissue is rich in its vascular component so that the blood must travel a greater distance and frequently must overcome increased peripheral resistance. The accumulation of fat around the heart, and sometimes in the myocardium, makes the work of the heart more difficult This accumulation ordinarily takes place in the interventricular and auriculoventricular grooves and over the surface of the right ventricle. The penetration of fat finally splits the muscular wall. thus inducing ultimate atrophy of the myocardium, and in some instances rupture or failure of the right ventricle The unduly elevated diaphragm, causing a decreased negative intrathoracic pressure, may increase the difficulties the heart has to meet Then, too, deposits of fat subjacent to the endocardium, especially along the conduction system, bring about the aforesaid effects Coronary heart disease is common in obesity, as is acute coronary thrombosis

It is known that increased peripheral resistance results in increased blood pressure. It is this effect which is the actual cause of the heart disease. According to Goldring and Chasis, abnormal elevation of diastolic pressure is the main criterion in the diagnosis of hypertension. It is always accompanied by increased systolic pressure. A systolic pressure of 150 and a diastolic pressure of 90 is considered the lower limit of hypertension.

In a certain percentage of obese persons (the data differ according to various authors), blood pressure is abnormally high Rony, for example found hypertension (over 150 systolic) in 19 per cent of his adult obese patients, Gager found, in 28 3 per cent of his obese patients, systolic hypertension compared to 164 per cent of the normal weight group, Short and Johnson found 6 5 and 26 per cent respectively 2-4 These investigators maintain that excess weight is a definite factor in the causation of increased incidence of hypertension This incidence is more striking in the diastolic than in the systolic blood pressure A statistical analysis of medical records of 22,741 officers in the US Army showed significantly higher rates of later sustained hypertension in overweight persons than in the control group 5

The question arises Is the pathologic hypertension caused solely by obesity or by a disturbance of the unknown mechanism which controls the normal level of blood pressure independent of excess weight, or are both factors responsible?

The question is apparently unanswerable at the present time. The basic cause or causes of essential hypertension are unknown. Deductions are based on the exclusion of all the diseases in which increased blood pressure is a symptom. Hypertension or heart disease, it must be stressed, is not always associated with obesity. Adiposity is, therefore, not the sole cause of the vascular changes. If it were the only cause, one would expect a correlation between the degree of adiposity and the incidence of hypertension. The age distribution would differ from that in people of normal weight.

It is well known that weight reduction to a certain degree has a favorable influence on hypertension in obese people. In an earlier paper, we reported that 8.8 per cent of 671 overweight patients had a systolic and diastolic hypertension. In this group, there was a noteworthy reduction of the hypertension in 58 per cent of the patients after treatment.

The present report is based on a study of 1,260 obese patients. One hundred and forty-nine (118 per cent) showed hypertension. Systolic and diastolic hypertension were present in 97 (65 per cent), diastolic in 17 (114 per cent), and systolic in 15 (10 per cent). Twenty (134 per cent) had a normal pressure at the start of treatment but developed hypertension during the course of treatment or within a few years.

Table 1 indicates the age distribution of the hypertensive patients

TABLE 1 -AGE DISTRIBUTION OF HYPERTENSIVE PATIENTS

Age-Years	Number of
	Patients
11 to 20	2
21 to 30	š
31 to 40	29
41 to 50	71
51 to 60	31
61 to 70	91
Over 70	9
Age Unknown	1

According to Cecil, 80 per cent of persons suffering from essential hypertension who are not obese are in the age group between forty and seventy ⁷ About 74 per cent of our obese patients with hypertension ranged within this age limit. Thus there is little difference in the age range of our patients and that of Cecil.

The percentage of overweight in 98 of our hypertensive patients is shown in Table 2

TABLE 2-PERCENTAGE OF OVERWEIGHT IN 98 HYPER

TRANSITE CALIFORNIA				
Per Cent	Number of Patients			
1 10 11 70	1 36			
21-30 21-40	86 22 18			
41-50 51-60	12 3			
61-70 71-60	4			
81-90 91-100	0 1			

These data are obviously inadequate to permit of conclusions concerning the correlation of hypertension with percentage of overweight We must, however, stress the fact that the number of our hypertensive patients who are only 10 to 20 per cent overweight is relatively large. This may, perhaps, be an indication that apart from overweight other factors are significant in causing hypertension in obese persons.

At the start of reducing treatment for the 149 hypertensive persons we found both systolic and diastolic hypertension in 97. Nineteen persons did not show any weight reduction and seven only negligibly. The cause of failure was, as usual, lack of cooperation on the part of the patient Nevertheless, the systolic and diastolic pressure fell below 150/90 in seven of these patients, and the diastolic pressure alone fell below 90 in one person.

The remaining 71 patients showed weight reduction A fall of the systolic and diastolic blood pressure to more or less normal range was noted in 35 patients, a fall of the diastolic pressure below 90 in three, and a fall of the systolic pressure below 150 in five. However, the readings remained abnormally high in 28 patients

It may be contended that the 28 patients did not show improvement in their hypertension because the weight reduction was not satisfactory. Their average weight loss was 11 per cent of their body weight. The average weight loss of the 35 patients with reduced blood pressure was only 13 9 per cent, or 2.9 per cent more than in the group of 28. The difference between the two groups was small, suggesting that other factors apart from obesity play their part in the causa

tion of hypertension

Again the question may be asked Why was there a reduction of blood pressure without weight loss and why lowered blood pressure so early as the second or third week of treatment? The weight reduction at that time was so slight that it could not be the cause of improvement. Freed who noted similar effects, attributes this phenomenon to the use of a combination of benzodine and phenobarbital We have been using the same combination of drugs for a number of years. However, we are convinced that the

lowering of blood pressure is not attributable to the use of these drugs. It is known that persons with essential hypertension, on occasion, have spontaneous lowering of blood pressure. This doubtless is because of interplay of dynamic factors normally controlling arterial pressure. One of the factors is emotional. Aroused confidence after a few interviews made the patient less emotional. This may explain the fall in blood pressure in this group

Some of our patients had only a diastolic or systolic hypertension at the start The first group comprised 17 patients and the second 15 In the diastolic group, eight patients showed no weight reduction. In the course of treatment are of the eight revealed development of a systolic hypertension in addition to the diastolic hyper

tension originally present.

One of the patients without weight loss and seven of the others had a fall of diastolic pressure below 90 In the second group of 15 patients with systolic hypertension at the start of treatment, five showed no, or only negligible, loss of weight. In two patients, in spite of nonreduction in weight, the systolic pressure dropped to normal, in contrast to eight patients who showed both weight reduction and a systolic fall to normal

In summing up, the interesting fact remains that with a reduction in weight, a full of blood pressure to normal was found in about one-half of our patients with both a systolic and diastolic by pertension, as well as in 80 per cent of those with either a systolic or diastolic hypertension alone.

Are the favorable results permanent or are they merely transient? We re-examined 21 of the patients after an average time interval of little more than a year. Sixteen patients prior to their first reducing treatment had a systolic and diastolic hypertension. Their re-examination showed the results listed in Table 3.

TABLE 3 —RB-REAMINATION OF 16 PATTERES FOLLOWING REDUCING TREATMENT

Blood Pressure	Number of Patients	Ex conive Weight Return	fimali Weight Return	Weight Un- changed	Weight Loss
Below 150/90 150/90 and	7	2	2	1	2
orer	9	8	a		

Of the nine studied with a weight return as well as a return of their systolic and disatolic hypertension, two showed a recession to normal blood pressure again after weight loss, one without weight loss, and six, although showing a loss of weight, revealed no corresponding effect on blood pressure.

Of the five remaining patients who returned for treatment after lapse of about a year on the aver age, three had previously had a diastolic hypertension and two a systolic hypertension on initial observation and treatment. Of the aforesaid three, one now showed, not, as originally observed, only a diastolic hypertension but also a systolic one. Another of the same three again showed a return only of the diastolic hypertension. In the third patient the diastolic pressure was still found to be normal. All three had gained weight

One of the two remaining patients with a systolic hypertension on first examination and treatment showed a systolic and diastolic hypertension on return after a similar absence, despite weight loss. The second patient showed a diastolic hypertension in contrast to an original systolic hypertension with weight remaining unchanged

In answering the aforementioned questions it appears to us that the improvement of the hypertension was transitory in more than half of our reexamined patients. It is undeniable that weight may influence blood pressure unfavorably. But we also see a similar state of affairs without weight gain and unchanged pressure in spite of weight gained. The inadequate number of patients studied does not permit any conclusion regarding the influence of a repeated reducing treatment on hypertension.

Finally, we studied a group of 20 patients who at the beginning of treatment showed a normal blood pressure. In four we noted increase of blood pressure to an abnormally high range during the first course of treatment, regardless of weight loss. In the other 16, the first high reading was noted after a time interval of four months to four years, on an average after one and seventenths years. Fifteen had a systolic and diastolic hypertension, only five had a diastolic hypertension.

TABLE 4 -- Weight Changes in 20 Hypertensive Pa-

Blood Pressure	Number of Patients	Weight Gain	Weight Less Than at Start	Weight Loss	Weight Un- changed
150/90 and more Dusatolic 90	15	8	в	5	2
and more	5	4	2	1	

The age distribution did not differ much from the previously cited table The patients belong rather in the group with greater overweight

In the group with systolic and diastolic hypertension, five had a more or less obvious weight loss, in two the weight remained unchanged, and eight gained weight. The weight of six of the later group, however, was 9 per cent lower on an average than it the start of their first treatment. Only one spatient of this group was

favorably influenced by a new course in weight re-

Of the patients with diastolic hypertension, four showed weight gains, and two weighed less than at the beginning of the first treatment One patient had a weight loss Renewed treatment was successful as far as the hypertension was concerned in only one patient

Hypertension was still noted in six of the group who showed a weight loss from the time of initial treatment. These, however, still had a percentage overweight which was too high. The remaining group of seven showed either a weight loss or unchanged weight but with a persistent hypertension. (There was one patient in this group who underwent a hysterectomy, another had a valvular disease, and still another a family history of hypertension. In the remaining group of patients we found no symptoms of disease in any way related to or associated with hypertension.)

It is evident then that only a relatively small proportion of our obese patients showed hypertension, and the majority was in the lower categones of overweight The age distribution of hypertensive, obese patients was almost identical to that in essential hypertension There is no uniform reaction to weight reduction. After a notable weight loss, a fall of blood pressure to normal levels was seen almost as often as no change in blood pressure Hypertension was likely to return in some of the improved patients after gain of weight, in others weight gain did not show any change of blood pressure within a year We saw hypertension develop in patients in spite of weight loss, and we also saw a fall of abnormally increased pressure to normal without reduction of weight

All this leads to the assumption that hypertension in obese people is not caused by obesity. The same factors which cause hypertension in nonobese people are apparently responsible for abnormally high pressures in the obese. Overweight only aggravates the condition. Weight reduction consequently may cause an improvement. The treatment is no cure because the hypertensive tendency remains. One of the aggravating factors may be removed by weight reduction, however, and the prognosis of patients with hypertension is thus improved. Early weight reduction and maintenance of normal weight are strongly indicated, therefore

Twenty-three, or 18 per cent, of our patients showed cardiac changes at the beginning of treatment. We found signs of valvular disease in two, probably the result of rheumatic fever. Eleven of the hypertensive patients and ten others showed only electrocardiographic abnormalities, suggestive of myocardial damage. The

electrocardiographic changes in the hypertensive patients were about eight times as frequent as in the nonhypertensive, obese patients. Those patients in the fifth and sixth decades showed most of the circulatory changes

Summary

- 1 Eleven and eight-tenths per cent of our obese patients had essential hypertension
- 2. Hypertension frequently is noted in the lower categories of overweight persons.
- 3 The are distribution of hypertensive, obese patients does not differ from that in essential hypertension
- 4. The influence of weight reduction on hypertension is an inconstant one
- 5 Hypertension in obese persons is caused by the same factors as in the nonobese. Obesity is only an aggravating factor

- Reduction of weight is therefore, no cure for hypertension in the obese, but it removes an aggravating factor and is therefore, strongly in dicated
- Abnormal electrocardiographic changes in our hypertensive patients were eight times as frequent as in the nonobese.

44 Cast 67th Street

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DR. DIAMOND TO SERVE ON ARC BLOOD PROGRAM STAFF

Dr Louis K. Diamond noted authority on hematology and assistant professor of pediatrics at Harvard Medical School Boston has been appointed technical director of the American Red Cross National Blood Program, Dr Ross T McIntire administrator of the program has an nounced Dr Diamond will plan and supervise technical phases of the new program, designed eventually to provide blood and blood derivatives to the entire nation without charge for the products.

RADIUM D-A NEW SOURCE OF BETA IRRADIATION IN OPHTHALMOLOGI

For a number of years a few ophthalmologists in the large medical centers have been utilizing the beta rays from large amounts of radon to treat a number of eye conditions especially corneal scars. Some brilliant results have been reported but the expense in carrying out the procedure has been so great that the treatment has not been popular A. D. Ruedemann, professor of ophthalmology at Wayne University who has given over 5 000 bota irradiation treatments with radon has been

using one of the Radium-D applicators for three

a 10-mc. applicator he finds a two-minute contact application produces approximately the same clinical results as a twenty-second exposure using 250 mc. of radon but with less local reaction. The fact that a relatively small amount of Radium D can be used to do the clinical work of a much larger amount of radon or radium-element makes the new applicator much more economical to use and, therefore, makes beta irradiation more readily available. Rucdemann has established the first Radium-D Clinic at the City of Detroit Receiving Hospital Detroit.

CLINICAL STUDIES IN JAUNDICE

The Use of Sedimentation Rate Determinations in the Convalescent Stage of Infectious Hepatitis

A Allen Goldbloom, M.D., F.A.C.P., Abraham Lieberson, M.D., New York City, and Charles D. Rosen, M.D., East Orange, New Jersey

(From the Medical Service, Station Hospital, Camp Kilmer, New Jersey)

SINCE the essential pathologic process in acute hepatitis is the infection of the biliary radicles, it was reasoned a priori that the course of the disease would be best followed by a test such as the crythrocyte sedimentation rate During the wide experience with infectious hepatitis of World War II, this reasoning was shown to be fallacious. Almost all investigators reported a normal sedimentation rate in the early weeks of acute infectious hepatitis. This failure of the sedimentation rate to register the presence of the infectious process has received a great deal of attention.

The careful experimental work of Miles suggests that the increase in bile salts may cause the inhibition of the erythrocyte sedimentation rate in the pre-icteric and early icteric phases of the disease 1 Wood felt that good use could be made of the fact that the sedimentation rate remains normal during the first few weeks of infectious hepatitis in differentiating it from clinical malaria 2 The necessity for this differentiation is often present, not only in military medicine but wherever malaria is prevalent or endemic Wood reports that in the first ten days of infectious hepatitis about 85 per cent of the cases show a sedimentation rate below 10 mm (Wintrobe), while in the first ten days of malaria about 85 per cent of the cases show a sedimentation rate above 10 mm

We had the opportunity of studying this question on the medical wards of the Station Hospital, Camp Kilmer, New Jersey Our findings agree with Wood's in so far as they show that the vast majority of cases of infectious hepatitis have normal sedimentation rates (below 10 mm) during the first ten days of the disease However, in the first ten days of malana only 58 per cent of our cases had a sedimentation rate above 10 Table 1 shows the sedimentation rate in 36 cases of malaria studied during the first ten days of illness at a period when there were chills and fever None were jaundiced, all having icteric indices under 10 Note that fully 42 per cent of our series showed a sedimentation rate of 10 mm or below (Wintrobe) It would be hazardous to differentiate between malaria and infectious hepatitis on the basis of such a variable finding

The unrehability of the sedimentation test during the early stage of infectious hepatitis threw the test into such disrepute that many investigators gave up its use entirely in this disease Thus, Barker, Capps, and Allen report it as unreliable and of no value 2 On the other hand. many investigators, such as Hoagland and Shanks, Fink and Blumberg, etc., found that after the first few weeks of the disease the sedimentation rate rises to 25-50 mm and remains elevated during the early period of convalescence, falling to normal levels late in the period of recovery, 1 e, after fifty-five days on the average 4 5 Thus, Zimmerman and his coworkers found that the persistence of an elevated sedimentation rate during convalescence indicated continued or renewed activity of the inflammatory process in the liver 6 If such patients were exercised, they would usually relapse

We also have had the opportunity of studying the usefulness of the sedimentation rate in the

TABLE 1 -THE SEDIMENTATION RATE IN 36 Cases of

PROVED MALARIA*		
Case Number	Sedimentation Rate Mm.	
1 23 4 5 6 7 8 9 10 11 12 13	6 10 58 21	
3 4	58	
Š	1	
7	15 29	
8 9	68 45	
10 11	78 88	
12 13	10	
14	4 15 29 68 45 73 33 10 40 10 35	
14 18 16 17	70	
18	15 18	
19 20	18 20	
$\begin{array}{c} 21 \\ 22 \end{array}$	62 38	
23 24	68 7	
25 28	Š	
27	2	
29	10	
31 31	10 13	
18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35	15 18 20 62 38 68 7 8 4 2 3 10 13 23 6 6 5	
34 35	6 5	
36	10	

^{*} Total number of normal sedimentation rates was 15, or 42 per cent.

TABLE 2.—The Sedimentation Rate as Compared with the Cephalis Plocutlation Test in 25 Cases of Impedtious Hepatitis in Recovery Pease

TIOUS HEPATITES IN RECOVERY PRASE				
Case	Bedimentation	Cophalin Flocculation		
Number	Rate, Mm. per Hour	(Forty-eight Hours)		
1	12	0		
	46 14	- i		
3	14	4		
4	64	•		
å	11 25	à		
7	41	i i		
2 3 4 5 7 8 9	41 29 24	4		
.0	24	4		
10	40 27	1		
11 12		ã		
18	14 34 36 60 23	3		
14	36	3		
15	60	2		
15	73	3		
iń	24	ã		
19	87	4		
20	34 57 81 35 32	2		
21	35	ŭ		
# H	37 20	•		
21	43	ă		
18 14 16 17 18 19 20 21 22 24 25 25	34	4333022334202233002		
26	35	2		
Total	25 Positive	15 Positive		

convalescent period of acute infectious hepatitis at Camp Kilmer We have found it even more sensitive than the cephalin flocculation test in determining recovery from the disease. Table 2 shows 26 cases in the recovery phase of infections hepatitis in which the question of persistence of activity came up. In all cases the patients were clinically "cured" of the hepatitis, the ictence index was normal, and the question of discharge came up If we consider 3 plus or higher cephalin flocculation or a sedimentation rate of 10 mm. or higher as positive, it will be noted that in 15 of the 26 cases the flocculation test was positive, while the sedimentation test was positive in 25 Therefore, we consider the sedimentation rate more sensitive than the cephalin floceu lation test in determining complete recovery from infectious hepatitis and a better basis for the conservative treatment of the patient. Since the sedimentation time is such a simple office procedure with which all doctors are familiar, we use and recommend it as the test of choice in civilian practice for determining the persistence of infection after the acute phase of infectious heratitis.

Summary and Conclusions

The sedimentation rate is not increased in the early stage of acute infectious hepatitus, probably because the bile salts have an inhibitory action It is also unreliable during the first ten days of malaria, since fully 42 per cent of our series showed a normal rate. The sedimentation rate cannot be used as a test to differentiate acute infectious hepatitis in the pre-leteric stage from The sedimentation rate, on the other hand, is very helpful in determining whether recovery from acute infectious hepatitis has occurred. At the beginning of the recovery phase the sedimentation rate is usually still elevated but this drops to normal when recovery is complete We found this simple test more reliable than the cephalin flocculation test in determining when recovery is complete enough to permit the patient to resume his usual activities without fear of relapse It is, therefore, equally applicable to civilian as well as military practice.

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IN FACTORIES, MEN EAT BETTER

Among factory workers, men eat better than women, State Health Commissioner Herman E Hilleboe concluded in March after a survey of industrial employes in Utica and Troy Nutri tionists found that the average man consumes 96 Gm. of protein a day as against 59 Gm for the women. Men eat more milk, meat, eggs and bread women eat more vegetables.

PSYCHIATRIC ASPECTS OF THE EVERYDAY PRACTICE OF MEDICINE

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THE psychosomatic aspects of various dis-orders are being emphasized at medical meetings and publicized in periodicals The physician is cognizant of the role that the emotions play in the illnesses which he treats, yet the handling of the patient with proper heed to emotional asnects is not, at least at present, a ubiquitous virtue among physicians. In the psychiatric clinic many patients are seen who were mishandled, because the physician lacked insight into the emotional make-up of his patient result, the patient's condition was not improved, and the physician often became ineffectual This paper is not written in criticism of medical treatment or to extoll the virtues and accomplishments of psychiatry There is no need for any dichotomy of thinking to exist between the psychiatrist and physicians in other fields of medi-Today, the practitioner cannot afford to treat a patient without investigating the emotional component any more than the psychiatrist can treat an acute abdomen in his patient without benefit of surgery Therefore, this paper is written with the belief that the knowledge gleaned from the study of the emotions of people should be incorporated into the procedures employed in the everyday practice of medicine

Fear

Medical education for the laity today is specifically directed toward stimulating the basic Thus, the public is warned about emotion, fear venereal diseases and their complications cently, the cancer drive has educated the public to the clinical aspects and early signs of malig-Billboards, displaying the hand with pointed finger, remind the onlooker that he might be the one in ten to contract this or that disease It is true that emotional appeals of this nature are effective, and it is the duty of the medical proression to arouse the larty to insure public health It often has been said in defense of such publicity that no one has died from fear of cancer, but many have died of cancer

In the final analysis, it is fear that brings the patient to the physician's office, and it is the doctor's job to allay this fear which he has, in part, stimulated This may be accomplished by active treatment of the disorder at hand or by reassurance. When the patient leaves the doctor's office after a reassuring examination, stating "I feel better already, doctor," he means exactly

The fear which he had been experiencing was now dissipated The physician had proved his competency, one part of his job had been successfully accomplished However, an unskilled examination may not only increase fear in the patient but may also contribute to a fixation of fear, and the organ or system causing apprehension in the mind of the patient may become invested with an inordinate amount of psychic Then, the patient is spoken of as heart conscious or bowel conscious
It is true that the patient's predisposition plays an important part in the formation of such fears and fixations, but indiscreet handling can cause much anxiety, even in the supposedly normal patient The history of C W T illustrates this point

Case 1—This patient was a 29-year-old man who had always been in good physical and mental health. With his brothers, he had established and operated a successful business which had placed him in the upper income bracket. An older brother, aged 43, also associated with the business, became ill of generalized carcinomatosis and died within twelve months. The presenting symptom of this man had been low back pain. At first, the attending physician had treated the local symptom but soon recognized the presence of a malignancy in the colon with metastasis to the lumbar spine.

Three weeks after the death of his brother, W T also began to experience low back pain Without consulting his family physician (an error made by many patients), he visited a specialist In addition to a thorough physical examination, blood was drawn for sedimentation studies, and extensive x-ray films of the spine were taken. On a return visit, the patient was told by the physician that although he felt there was nothing organically wrong with his back, the sedimentation rate was 15 mm per hour, a few points higher than normal In addition, the physician, apparently interested in demonstrating his thoroughness and perhaps in a naive way attempting to reassure the patient, showed C W T the x-ray films of his vertebral Unfortunately, there was a congenital anomaly at the second lumbar vertebra, the vertebral arches had failed to fuse completely at this level. The patient was then told that it was unlikely that this was the cause of the pain and that it was nothing to worry about. The patient left the office with a confused knowledge of the intricacies of embryology and of congenital defects but with a very certain knowledge, in his mind at least, that his spine was imperfect—unlike the spines of other people-and hence abnormal. Then, the significance of an increased sedimentation rate troubled him, and

it was not long before he learned that an increased esdimentation rate is found when cancer is present. It is needless to say that his initial fears were now well kindled. The backache became worse Much of his psychic energy became firmly but unprofitably invested in his back, and the fear of malignancy became well established It took months of reassurance to undo the work of one physician who had miscarried his job of allaying fear

It is redundant to say that laboratory tests and data, as well as physical findings, are of value to the physican only From them, he makes a proper evaluation of the problem which he is asked to solve The patient has no place in the sanctum annetorum of medical knowledge of which he can understand only a dangerously small fragment. Applied to himself, the axis of his universe, a sedimentation rate slightly above normal is of no little importance.

Transference

The effectiveness of therapy depends to a great extent on the patient and physician relationship and the rapport that is established It is true that insulin will have the same effect on carbohydrate metabolism no matter who mjects it, but the degree to which the diabetic follows the in structions of the physician as to diet, exercise, and use of medication may very well depend on his relationship with his physician This relationship may be determined by the phenomenon of transference. This term, originally applied to patient-therapist relationship in the field of psychiatry, is also found in the everyday practice of medicine. The patient's attitude toward the physician may be based on the identification of the physician with another person or experience in his past. Dumbar states "Transference has been called the sum total of the irrational elements of the patient's attitude toward any other individual (especially the physician)—a sort of mirror image of all his community relationships."1 The physician is judged frequently as a good or had doctor not so much by his training or the treatment administered but on the basis of wholly rrational elements, namely what he represents to the patient. It is not an uncommon occurrence for a patient to storm out of the office of a most talented physician with a curse on his lips yet find in some obscure physician the reborn Hippocrates.

Transference can cause much difficulty in medicine. Great physicians are made humble by it, and unfortunately much quackery can result from it. It is the work of the emotions which obfuscates objectivity The physician is loved and respected or hated and disregarded, depending on what he may represent to the patient.

Case 2 -The patient, F C K a 23-year-old

woman visited her oculist frequently because of conjunctivitis. She apparently became enamored to her physician for later she exclaimed to a frend. I felt like putting my arms around him and kissing him. Further investigation revealed that the physician in question was the same age and build as the patient sown father. She had fallem in love with a father image. The practitioner who uses such transference for other than professional pur poses usually finds himself in a very unenviable position.

Case 5—M R. T., a 22-year-old man, became acutely ill ax months after his discharge from the army It was discovered that he had diabetes. His course was storm, for he completely disregarded the instructions of a very competent intermst to whom he was sent. The physician in question was very aggressive, dogmatic, and over bearing. He demanded strict obedience from the patient in following the regimen prescribed He warned of the complications and harm that would come to the patient if his instructions were not followed to the letter

The physician represented the punishing father The patient stated "I had enough — — in the army I had to take it from the ninety-day wonders but I m paying for this and I'll be damned if I'll take it from him." It was apparent that the pa tient had difficulties with other father images. In this case the physician, giving the patient strict orders and warnings of morbid complications, had rekindled in the patient his hatred for all persons in authority (previously shown in his army maladjustment) All this stemmed from the hostility toward his own father and diffusion of hostility (transference) to all father images. Thus, the in ternist with his superior body of knowledge was totally unable to treat this patient effectively The case of F C K. showed positive transference, the last case demonstrated negative transference. Both extremes are undesirable they are emotion ally determined and have all the shortcomings of emotional relationships.

The handling of cases of this nature is difficult. but they are amenable to proper treatment Alexander and French have described the han dling of transference in their patients.2 Of primary importance is an evaluation of the patient to ascertain the relationship that may exist between patient and physician If the physician is identi fied with a cruel father, he must do all in his power to throw off this cloak. The patient must be handled with kindness and understanding physician would be wise in these cases to lean over backwards, substituting a kind father for a cruel one. The patient may become puzzled and pleasantly surprised at handling which he had not expected, and on this basis much more can be done for the patient in his medical treatment.

The flow of energy of transference may be in the opposite direction. Thus the physician's objectivity toward his patient may be tempered by his emotional feelings (counter transference) The patient may be identified with some other person or situation. This phenomenon also is seen in the attitude of the physician toward certain disorders and in fact, may determine the specialty that he follows. A physician to whom alcohol has been a constant threat may be extremely intolerant and even cruel to alcoholics who visit him. It is the obligation of every physician to recognize his own emotional problems. Counter transference vitiates a healthy rapport between patient and physician.

The Anamnesis

The patient, upon entering the office, must be made to feel that the physician is sincerely interested in him, for here is a doctor with a body of knowledge gleaned through the ages by the world's greatest minds. Here is a healer whose sole interest, for the moment, is the application of the best of his knowledge to the one person before him. This is the responsibility of the doctor—to apply it with sincerity

Sincerity serves to put the patient at ease He is made to feel like a human being instead of another case history. He has found someone who will unselfishly and unstintingly look after his welfare

The physician in the everyday practice of medicine cannot be expected to do a mental examination, a psychosomatic history, in addition to the medical history and examination However, since an adequate psychosomatic evaluation is essential in the treatment of all patients, pertinent information can be ascertained within the framework of the classic form of history taking. The following suggestions will aid in eliciting the emotionally determined disorders as well as the emotional components in organic disease.

Present Illness — The physician is well aware of the fact that an accurate description of the presenting symptoms is the sine qua non of diagnosis. Here, semantics play a large role. It is characteristic of many patients that, being unable to describe their symptoms adequately in terms which they feel the doctor will understand, they will come to the physician saying that they have an ache or pain. Or, they may come with a prefabricated diagnosis of stomach trouble or heart trouble

Hinsie described the patient whose presenting complaint was stomach trouble. The patient was asked to describe the nature of his complaints in detail. The stomach trouble was described as a "cylindrical object, tissue in nature, about eight inches long, located first in the groin then in the abdominal wall. It got rigid and mobile, following which it exploded, leaving him exhausted." The actual description revealed im-

mediately that the stomach trouble was emotionally determined and, furthermore, that it was unrelated to the stomach. The author has reported a similar instance of head sensations in a young woman whose presenting symptom was severe headache. A detailed description easily determined the psychosexual nature of her disturbance

It has been repeatedly stressed that the cognizance of an emotionally determined disorder need not be reached by elimination of organic conditions. The diagnosis can be made positively from the symptom complex described by the patient, if the patient is encouraged to describe the quality and nature of his symptoms without being encumbered by stereotyped expressions which the patient feels he must use to make the physician understand him

Case 4—A. P had visited numerous doctors and clinics because of what he described as pain in the back. When an exact description was asked, he indicated that there was no pain at all but a peculiar sensation like shooting needles which started in his lower spine and shot up to the back of his head. A description such as this makes the diagnosis evident without further laboratory procedures. Deeper analysis brought forth the strong homosexual component in his make-up. True, it is not the job of the practitioner to uncover the psychopathology in these cases, but the recognition of the nature of the symptomatology is most important for the welfare of the patient and saves the physician infinite time.

One aspect of the patient's status which is most frequently missed by the practitioner is the presence of a depression. Ripley in studying 150 patients in a general hospital found depression reactions in 100 who were also suffering from physical disease ⁵ A psychiatric disorder was found to be the sole cause for hospitalization in 24 cases. The signs in the reactive depression group were poor appetite, loss of weight, sleep disturbances, excessive variation in pulse, moderate constipation, and decrease in sexual desire.

The underlying depression often is masked by a labyrinth of physical complaints This is especially true of the involutional group and again, although the physical complaints are exhaustingly investigated, no attention is paid to the mood of the patient To the question, are you depressed, the patient may answer in the negative, often because the patient does not There may understand the meaning of the word Agitation, if be little retardation evident present, may be attributed to his worry over his Yet, in response to the question, symptoms does life seem worth living, the patient may burst The floodgates of the emotions are into tears opened, and the true nature of the illness discovered. It is often as simple as that. To the question, how do you feel, the patient may respond with an enumeration of his physical complaints. The question, how are your spirits, will be more productive. This is directed to his inner life and to his outlook, in comparison with his former mood.

Many physicians are prone to think that the depression is secondary to the many physical symptoms, a reaction of the patient to physical illness It is not denied that a depression may follow a prolonged illness, but in the overwhelm ing number of cases seen in the outpatient clinics, the somatic complaints are the symptoms of an underlying depression Closer questioning will reveal an inordinate amount of guilt feelings Trivialities of early life are recalled and magnified to gargantuan proportions. Patients express their unworthiness and tell of what a burden they are to their loved ones They volunteer the information that they are such physical wrecks that it probably would be better for everyone if they were dead Frequently, they describe themselves as tense inside, with no energy to do anything constructive Needless to say, if the depression is unrecognized, and hence untreated the chances of suicide are great

Past Hustory -The early development of the patient may reveal the beginning of a neurosis. It is important to elicit neuropathic traits such as temper tantrums, nightmares, bed-wetting, somnabulism, and nail-biting. Also the reaction of the patient to early illnesses may be a clue to reactions pertaining to the present illness. Some patients have been the object of oversolicitude, illness may become an attention-getting mechamam and be responded to by much fretting by overanxious parents and relatives. These points, in addition to facts about the actual illnesses, should be noted. Oversolicitous parents often receive gratification from nursing their children and by so doing often exploit them. R.M, at the age of 26, remains an invalid eleven years after his recovery from acute nephritis At that time, the physician ordered a low protein diet and instructed the mother to weigh out 4 ounces of ment per day as the total protein intake during the acute illness However, following a complete recovery, the mother persisted in measuring the protein intake and restricting both social and physical activities. As a result he developed erratic cating habits, including an aversion to meat. In addition, he has become markedly introverted, and his whole life is geared to preserving his kidneys, although at present there is no demonstrable evidence of kidney damage.

Family History —This is a frequently neglected part of the history but may be of great importance from a dynamic psychosomatic point of view It is not enough to record familial discases, cause of death of parents, and their age at time of death. It is of greater importance for an evaluation of the total personality to ascertain the age and emotional reaction of the patient at the time of familial illness and death. Thus, the case of C W T, cited earlier in this paper, proves this point. It was of utmost importance not only to ascertain the cause of death of the brother but to learn the patient's reaction to it. Thus the patient, having always been closely identified with this sibling, took on his symptomatology Hidden guilt because of a feeling of responsibility for the brother's death made punishment for himself necessary

This case also demonstrates another significant point. The patient had the presenting symptom, low back pain, which was the initial symptom of his unfortunate brother. Thus, to learn that the brother died of cancer would give the physician little insight into the patient's symptomatology. But if he had known the characteristics of the brother's disease, he would be on the road to an understanding of his patient's complaints. Therefore, it is wise to ask the patient for a description of the disease that has occurred in the family as well as the diagnosis. The patient will understand little of the pathology but will be well aware of the symptomatology of the diseases which have afflected those does to him.

Dunbar has placed great emphasis on the necessity of learning the emotional reaction of the patient to illnesses of other members of the family * Frequently, symptoms come on after nursing and caring for a chronically ill parent. The ambivalent feelings aroused by such an emotionally, as well as physically, arduous task leave their mark.

Sibling relationships should be recorded. The attitude of the patient at the time of the birth of siblings is important. Sibling ravalry may become translated into definitive syndromes

Case \(\epsilon \)—One example of this is the woman patient, I. L. agod 23 now suffering from severe neurons and headaches dating back to the age of 6. In the course of taking the history in regard to menstruation she exclaimed, "I hate being a woman, having to be sick each month I always wanted to be a boy, I love outdoor sports. When I was younger I would wrestle with my younger brother I fought fairly but he would scratch and pull hair like a woman."

The birth of the younger brother occurred when the patient was 6 years of age also the time of onagt of her head complaints. Here the birth of a boy was a great threat to this girl. She had sensed the feeling in the household of a great deeire for a boy child. In an unconscious attempt to satisfy the parents, she had assumed the masculine role. The appearance of the infant caused her to muster all

her defense mechanisms to the point of attempting to feminize her brother However, confronted with the overwhelming obstacle of biology, she could not maintain her desired status, and symptoms resulted

With the above elucidation of the subheadings, the following outline is designed to include an evaluation of the emotional aspects of the patient's illness in the routine anamnesis the main considerations in its formulation was brevity so that it can be a workable tool in the everyday practice of medicine

Present Illness

- Chief complaint, duration, progress
- Description of quality and nature of symptoms
- Relation to environmental factors to the present illness
- 4. Mood

В Past History

- Early development
- Previous illnesses
 - Reaction of patient to illness
 - **(b)** Reaction of parents to patient's ill-
- Habits of eating, sleeping, drugs, etc
- Menstrual history
- Marital life

- Employment
- Review of systems
- Family History
 - State of health of close relatives
 - Description of familial illnesses
 - Emotional response of patient to familial
 - 4 Sibling relationship

Summary

Factors of fear and transference in patientphysician relationships are discussed fied outline for the anamnesis is formulated to include an evaluation of emotional components Pertinent case histories are presented emphasis of this paper is on the recognition of the psychiatric aspects of everyday clinical practice

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WORLD HEALTH ORGANIZATION RESOLUTION

"Whereas, the United States of America played an important part in organizing the International Health Congress, held in this country, and which led to the setting up of the World Health Organization

Interim Commission, and "Whereas, the establishment of the World Health Organization on a permanent basis is essential to the health and security of the United States, and its program is one of the noncontroversial activities of the United Nations which all of the United Nations have unanimously agreed to support wholeheartedly, and

"WHEREAS, even though enough nations have now ratified the Constitution of the World Health Or-

ganization, or have signified their intention to ratify within the near future, to permit its establishment on a permanent basis, the Congress of the United

States still has not so ratified,
"Be it resolved That the Board of Directors of the National Tuberculosis Association hereby urges strongly that the present Congress approve the Constitution of the World Health Organization without further delay, and without any crippling reservations, so that the United States can play its proper role in this important stage of the selection of personnel and formulation of policy for the World Organization "-National Tuberculosis Association, April 5, 1948

PROSTATECTOMY—SUPRAPUBIC AND TRANSURETHRAL

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AUCH HAS been said and written concern-M ing the operative surgery for the relief of prostatic obstruction. There is today no una nimity of opinion as to the type of operation which should be employed in a given case. There are the ordent, so-called "resectionists ' who beheve that all, or nearly all, conditions of hyper trophy can be treated adequately by transurethral resection, while others believe that this operation should be definitely more limited The cutting type of operation is performed by either the suprapubic or perineal approach Some surgeons perform only the suprapubic method others use the perincal almost exclusively, while still others use both It has been aptly stated that a competent urologist should be must be considered as an individual problem and the elective method should be applied with the experienced judgment of the urologist

In the suprapubic operation there are those who adopt the two-stage method almost exclusively, while others favor the complete one-stage operation, after preliminary urethral catheter drainage. Some have felt that the permeal method should be a much more common procedure

An increasing experience with the complete one-stage operation during the past six years has convinced us of the advantage of this oper ation, except in the presence of nitrogen reten tion, proseptis and where wrethral catheter drainage is not feasible Certain cardiovascular lesions and debilitated states also may make the one-stage operation too dangerous.

The amount of preoperative drainage required for safety has been the subject of much discussion Seven to ten days of continuous drainage have usually been considered adequate in the average case. More courageous urologasts have claimed good results without such interval of drainage, except in the presence of nitrogen retention or serious cardiovascular disease.

A major factor in the controversy seems to be that good results reported by one group with one operation cannot be duplicated by others is especially true in transurethral resection It is a fact that the technical ability of various surgeons differs according to the experience with this procedure of each individual

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It is our opinion that transurethral prostatic resection, although a safe and adequate procedure in experienced hands, should be reserved for those patients with predominant hypertrophy of the median lobe and bar, coarctation of the vest cal neck, and periurethral fibrosis of the prostate. This policy is at definite variance with the school of enthusiastic resectionists. However, we have encountered many urologists who are reluctant to resect the very large so-called "adenomas" We do not employ the permeal operation.

There are indications that the complete onestage operation is definitely increasing in popul larity and that it has given equally good results as compared to the two-stage It has the advan tage to the patient of only one operation and usually a shorter period of convalescence

We believe that the two-stage operation should be reserved for a limited group, as follows (a) Those in whom adequate preoperative

catheter drainage is impossible without resort to evatotomy

(b) Those with marked impairment of renal function, cardiovascular disease, marked arteriosclerosis, or urosepsis which definitely contrainds cates prostatectomy Certain of these may be made safely operable at a later date by cystotomy drainage and other supportive treatment. There is an extremely limited group where prostatectomy cannot be considered even reasonably safe In these, permanent cystostomy dramage or catheter life is the only recourse.

Intermittent cathetensation two or three times in twenty four hours in some poor risk cases fails to give adequate symptomatic relief, in these

cystotomy must be done.

In any event we believe in the principle of "giving the beggar his chance" when it comes to cystotomy and prostatectomy, where, otherwise, nothing is left but a life of suffering The idea of refusing to take chances in prostatic surgery, just for the sake of low mortality statistics of the operator, is only to be condemned

Technic of Operation and Postoperative Care

Moderate sedation is given one hour before operation (morphine and scopolamine) Spinal anesthesia is employed exclusively, using 100 to 120 mg of procaine

With the patient in Peterkin position (legs flexed and thighs abducted) a paramedian vertical muscle-splitting incision is made, the bladder exposed, partially mobilized, punctured near the fundus, evacuated, and explored. The bladder is inspected carefully with the aid of illuminating bladder retractors. Search is made for possible tumor, stone, diverticulum, or other lesion, in those patients who have not been cystoscoped before operation.

With the left index and middle fingers in rectum the lateral lobes are steaded and slightly The right index finger then is made to perforate the prostatic urethra well below the internal vesical neck and in an anterolateral direction either to right or left. A line of cleavage is easily made between gland and capsule, and one lateral lobe at a time is enucleated readily Only in the presence of firm fibrous or malignant changes is there any difficulty of separation this instance, some cutting dissection may be re-Usually, one lateral lobe is removed first, then the other lateral and median lobes together Sometimes the entire prostate is easily removed en masse, although this is definitely to be avoided in quite large prostates (to minimize risk of hemorrhage)

Following enucleation of the "adenoma," the prostatic bed is bathed in a 2 per cent solution of acetone-alcohol-mercurochrome A temporary 2inch plain gauze pack then is placed in the prostatic bed for immediate hemostasis then withdrawn and the entire bladder neck and prostatic bed carefully inspected under vision with the illuminating retractors. Any bleeding vessels at the vesical neck are clamped and ligated with No 1 plain catgut suture ligatures Three, four, or five strips of oxycel gauze (cellulosic acid) are snugly placed in the prostatic bed Pressure is then made against this gauze with stick sponges for a few minutes, which usually controls bleeding adequately A No 38 or 40 French, open-end Pezzer tube is placed at the fundus and bladder-wall incision closed with interrupted No 2 chromic catgut sutures passed through the outer coats (avoiding the mucous membrane) A large wet cigaret drain placed in the space of Retzius, and the abdominal wall is closed in layers, approximating the skin with black silk, passing one through the tube to anchor it

After operation, intravenous infusion of glucose is given and repeated as necessary. Bleeding is usually slight to moderate, especially since the advent of the new hemostatic gauze (we formerly used vaseline gauze pack). The bladder is gently irrigated every three hours with weak adrenalin solution (40 drops to the quart) to avoid clotting in the tube. If the bleeding is more than average, 2 cc of neohemoplastin is injected intramuscularly and repeated as necessary. In our experi-

ence, blood transfusions are required only in exceptional cases

Postoperative bladder spasm is rather annoying in some patients. Moderate doses of morphine, atropine, depropaney, trasentine, octin, or phenobarbital may be employed variously. We have not yet found the ideal antispasmodic for all cases.

The judicious use of a sulfa drug (moderate dosage) has proved very helpful, both prophylactically and therapeutically, for urinary tract and other types of infection. We favor sulfacetamide and sodium sulfathiazole in ½-Gm doses in preference to other sulfa drugs. Penicillin and streptomycin also have played an important role in the management and control of these infections. We believe these new agents have accomplished a great deal in the reduction of morbidity and mortality

Keeping the urine acid, by the use of acidifying drugs and diet, is especially important after the operation. This is essential to proper healing Alkaline and urea-splitting infections must be avoided. Ammonium chloride, ammonium nitrate, sodium and ammonium acid phosphate are the most popular. In the presence of low renal function with acid therapy the patient must be carefully watched for possible occurrence of acidosis.

The prevesical cigaret drain is removed on the third postoperative day. The suprapulic tube is removed generally on the third to the fifth day. This, of course, applies only to the complete one-stage operation.

All instruments are kept out of the urethra until the seventh to the ninth day, and then a 22 F six-eyed catheter passed and the bladder thoroughly irrigated and completely cleansed

Because of the desire to keep the patient moving in bed and for relatively early ambulation, suprapulic suction apparatus is used very little by us at present

*Fairly early voluntary voiding of at least part of the urine usually takes place, otherwise, an indwelling multi-eyed urethral retention catheter is fastened in position to keep the patient dry. The bladder is kept clean with irrigations of oxycyanide of mercury solution three or four times in twenty-four hours.

We wish to emphasize that there is no field of surgery in which more meticulous supervision and care of the patient is required than in the managment of the prostatic patient. Only in this manner may satisfactory results be obtained

Results

Between the years 1939 and 1947, there were 283 prostatectomy operations performed on our service Ninety-one were transurethral resection, 119 were one-stage suprapubic prostateotomes, and 73 were two-stage suprapubic prostatectomics. The average age of the patients was sixty-six and one-half years The youngest was fifty years of ago, and the oldest was ninety one. Sixty-seven per cent of these patients had important preoperative complications, the most common of which were arteriosclerosis and heart disease.

The average period of preoperative drainage for the transurethral operation was three days. This included some with no preoperative drainage. The average period of draininge for suprapuble

prostatectomy was nine days

Malignancy was found by the pathologist in 47, or 10 0 per cent. Of these 28, or 59 per cent were diagnosed preoperatively Two hundred and thirty-six, or 83 4 per cent had benign hyper-

trophy of the prostate.

Twenty four per cent had some postoperative complication, of which hemorrhage and urinary lever were the most common. The average total hospital stay was nineteen days for the transurethral, thirty two days for the one-stage supra pubic, and thirty-six days for the two-stage su prapuble operation

The over-all results were 81 per cent good, 13 per cent fair, and 6 per cent poor including mor talities The results classified as fair were based upon the discharge note on the chart and were largely conditions of frequency, urgency, noctuna, or dysuria incident to residual bladder in fection, which conditions are generally amenable to local and general follow up treatment.

There were six postoperative deaths, or 2 12 per cent one following transurethral resection, three following one-stage prostatectomy and two following two stage prostatectomy Of these three succumbed to coronary thrombosis, two to

uremia, and one to acute cardiac failure.

The mortality in the different types of opera tions was as follows for the transurethral opera tion, 11 per cent for one-stage prostatectomy. 25 per cent, and for two-stage prostatectomy. 27 per cent.

There were four additional deaths which were not included in operative deaths one on the forty-eighth postoperative day of pulmonary embolus one on the thirty-eighth postoperative day of bronchopneumonia and cardiac failure. one on the thirty fifth postoperative day of uremia, and one on the thirty third postoperative day of pulmonary embolus. These were all debilitated patients. However they had recovered from the effects of operative surgery If these are included in the postoperative mor tality of the entire group, the percentage mor tality is as follows for the transurethral operation, 11 per cent, for one-stage prostatectomy, 2.5 per cent, and for two-stage prostatectomy. 82 per cent

Two instances of persistent postoperative su prapubic fistula required secondary cutting resection and closure for complete wound healing No case of urinary incontinence has been recorded in the entire group

Summary

Two hundred and eighty-three cases of prostatectomy are reviewed Transurethral resection was employed in 91 cases, two-stage su prapuble prostatectomy in 73 cases, and one-stage suprapuble prostatectomy in 119 cases dications for the different types of prostatectomy The total mortality of the series are discussed was 2 12 per cent. Preoperative and postoperative care are outlined briefly, and surgical technic is described

> 480 HERKIMER STREET 306 PARK PLACE

BELLEVUE NURSING SCHOOLS MARK 75TH ANNIVERSARY

The 75th anniversary of the founding of the Bellevue Schools of Nursing is being celebrated be-pinning May 6 with a program which highlights the history and progress of the nursing profession as well as many of the advances made in medical science during the past three-quarters of a century The Museum of the City of New York has prepared an historical exhibit in conjunction with the celebration, and a fashion show and rovue of old nurses costumes will be held on May 19 at the nurses' residence.

The first school of nursing in the United States to be founded on the Nightingale Plan the Bellevue School of Nursing was opened officially on May 1 1873 at 315 East 26th Street, New York City Founded after approximately two years of intense effort, the opening class of the School consisted of any students. In 1888, the Mills School of Nursing for Men was founded as an affiliate of the Bellevue School of Nursing, and was the first nursing school for men in this country

Throughout its seventy five years of continuous service, a total of 3 602 women and 862 men have been graduated from the Bellevue Schools of Nurs-

ing.

INTESTINAL OBSTRUCTION COMPLICATING PREGNANCY

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INTESTINAL obstruction is not an uncommon condition. One meets it frequently in private practice but more so on the larger charity services of the public hospitals. The principles for its treatment have been well established, but how well understood are those principles when they exist as a complication of pregnancy? 1-4 Stressing the surgical principles and difficulties, as well as reviewing the obstetric problems, could improve and reduce the mortality and morbidity figures.

Despite the great change in the physical location of the intestinal tract during pregnancy, intestinal obstruction rarely occurs in the period of gestation. Gradual accommodation accepts the almost imperceptibly slow change in the relationships of the viscera as the organs are displaced toward the diaphragm.

The frequency figures of intestinal obstruction complicating pregnancy vary considerably Twenty-eight cases of pregnancy ileus were collected by Eliason and Erb from 1926 to 1937 5 Two hundred to 300 cases have been reported in the literature as usually due to a previous pelvic operation or appendectomy 6 In the previous ten years, 13 cases of obstruction have been reported with a maternal mortality of three and a fetal mortality of three From 33 other hospitals in Philadelphia, 12 antepartum cases were found in the same ten-year period with a maternal mortality of five and a fetal mortality of six These results are worse than those in the literature for the obvious reason that successful cases are more likely to be reported

Accordingly, general figures for the country at large must be similar or worse Block and Sales report two cases, one with two obstructions during the same pregnancy at the sixth month and ninth month 6 This patient had a cesarean section and rehef of obstruction with death of the fetus The second case was six months' pregnant and terminated uneventfully Both patients were operated on as acute emergencies without gastric suction authors believe in early operation with a thorough search and that conservative intestinal intubation should not be used in this condition Smith and Bartlett state that there was only one intestinal obstruction in the Boston Lying-In Hospital in 66.430 deliveries from 1916 to 1938 7 This patient was admitted as a late case, seven months' antepartum, she was operated upon at once and

died immediately afterwards Obstruction was due to adhesions without gangrenous gut cases of intestinal obstruction in 45,000 deliveries are reported for the previous twenty years from the Magee Hospital in Pittsburgh The causative factors were appendectomy in three, volvulus in one, and previous cesarean section in one 8 Immediate operation was performed in three cases with one mortality, one not operated upon, and one treated conservatively The last case delivered a four and one-half pound live infant, but twelve days later the obstruction was relieved by operation The fatal case was six and one-half months pregnant and died because at operation a gangrenous loop of gut was found Gastric suction was not used preoperatively. In a series of 80 cases, Hansen found a gradually increasing per cent of bowel obstruction as the pregnancy progressed A relatively high per cent occurred post-From the English literature, he repartum ported 25 per cent maternal and 36 per cent fetal Of 4,445 deliveries, from 1943 to 1946, inclusive, at the Sydenham Hospital of New York City, there was only one intestinal obstruction, in an abdominal pregnancy of twenty-week gestation

Eliason and Welty reviewed 202 cases of intestinal obstruction during 1934 to 1943 with definite reasons for obviously improving results 10 With the Miller-Abbott tube, the mortality was reduced 50 per cent Resection of bowel doubled the over-all mortality, 19 per cent compared to 11 per cent of the entire senes Twenty-five per cent of the patients to whom suction drainage was applied required no operation with special use for the Miller-Abbott tube in recent postoperative A delay in the successful intubation may be allowed, provided distention does not increase, a mass does not appear, and vital readings are satisfactory Strangulation is a strict contraindication to delay, yet gastric suction and proper intravenous medication for a short while are of benefit.

In an analysis of 130 cases of intestinal obstruction by Smith and Van Beuren, mortality of late cases gradually dropped from 66 6 per cent during 1916 to 1919 to 48 6 per cent in 1928 to 1931 ¹¹ From 1935 to 1939, the mortality was 23 8 per cent. The better results are due, the authors state, to the use of the Miller-Abbott tube, continuous gastric suction, and a better understand-

ing of the need and methods of correcting dehy dration and mineral balance

Case Report

F G., aged 37 para O gravida III pregnant seven full months, was admitted January 12 1947 because of recurring abdominal cramps following ingestion of food for six weeks duration. During the six days prior to admission ahe had not had a bowel movement nor passed any gas. Part of this time she had been in another hospital where she was treated with corpus luteum extracts to prevent what was considered impending labor. Two days before admission x ravs showed small bowel obstruction but the patient refused hospitalization.

On January 11 1017 the patient became markedly distended and she began to vomit fecal material profusely. She was treated at home with gastric suction which afforded some relief. The following day she consented to hospitalization because of severe pain and vomiting. The causative factor for the obstruction was a taparatomy done one and one half rears pruclously at which time a right tube over and appendix were resected when she was two and one-half months pregnant. This resulted in a prompt miscarriage.

On admission she was markedly dehydrated and distended Blood pressure was 140/80 temperature 100 2 F pulse 100 respiration 20 In addition to the pregnant uterus there was a nontonder mass palpable in the right lower quadrant.

Laboratory studies showed plasma protein to be 5.5 Gm, per cent hematocrit 37 52. Urine and blood counts were not exceptional She was Rh negative and her husband was Rh positive.

The patient was given 2.5 per cent gluco e in 1 000 cc. of saline alternating with 5 per cent glucose in 2,000 cc. of distilled water She improved markedly the following day. It was agreed that since the local mass had disappeared and the patient was better one should wait and continue treatment with the Miller Abbott tube and suction in the hope that the obstruction might be relieved. One of us (\ P) seemed reasonably sure that the patient would have no trouble delivering from below. Two co of mer cury added to the bulb of the Miller Abbott tube resulted in almost immediate advancement into the duodenum. The condition of the mother and fetus continued satisfactory so that operation was not deemed imperative However three days after admirdon it was decided to wait only one more day before intervention to avoid exhaustion of the pa tient On the afternoon of the following day labor was successfully induced by stripping and rupturing the membranes emptying the uterus of most of the fluid and inserting a Voorhees bag Nine hours later the patient gave birth spontaneously to a healthy five-pound five-ounce infant. During the night and the following morning the patient had ineffective enemata although some gas was passed

Since the obstruction was not relieved twelve hours later operation was performed through a mid right rectus incision disclosing the abdomen to contain about 250 co of clear straw-colored fluid. Beginning at the middle of the small bowel and extending almost to the terminal lleum were numerous bands adhedons and "knuckles" of small bowel attached to each other the broad ligament the cecum and the abdominal wall of the right lower quadrant some of which formed an internal hernia

Immediately after the operation the nationt developed anasarca, and plasma protein determination by the copper sulfate method was 4.4 Gm, per cent hemoglobin 13 6 Gm Serum chlorides were 610 5 mg per cent Following a transfusion of 500 cc. of blood and 500 ec of plasma, her proteins rose to 5.0 Gm, per cent with immediate improvement On the third postoperative day the patient was allowed two ounces of fluids by mouth each hour and the tube was clamped for one-half hour. On that morning it was noted that the patient was very apprehensive and she was given two grains of sodium phonobarbi tal intramuscularly Suddenly at noon, the patient had two severe Jacksonian convulsions Analysis of the laboratory data etc. indicated the cause as most probably due to alkalosis tetany. This was corrected by the sample expedient of removing the suction tube and administering glucose saline and sedatives

The patient was allowed out of bed on the sixth postoperative day apparently well. The following day the skin stitches wer. rumoved. Speedal adhesive strapping was applied to guard against dehiscence vet this occurred on the eighth day. The wound was immediately sutured with deep figure of eight stitches. Eleven days postoperatively the patient developed thrombophilebitis involving the left leg.

To relieve the edema of the leg and to open a good collateral circulation several left paravertebral aympathetic novocain blocks were done with good results. The patient was discharged improved on February 9 1947

This patient had been admitted precanously ill and suffering from malnutrition loss of fluids and minerals and sovere distention. It was originally intended because of a mass precent in the right lower quadrant to decompress and rators fluids minerals and proteins and very shortly thereafter to operate to relieve the obstruction. However with the routine treatment of Miller Abbott tube suction and hydration the patient improved and the mass disappeared. Because of this it was felt that further delay was advisable. Fortunately, until the time of active intervention the choice of election remained. The decision was made to induce labor.

Induction from below was chosen for these reasons

- (1) Although the cervix was long and uneffaced it was soft malleable and easily admitted one finger
- (2) Delivery from below would be least trauma tizing, and there was an outside chance the the obstruction might be relieved
- (3) Since a viable child was not expected (thirty-two weeks) and only the mother was to be considered vaginal delivery would be best for her. It was further hoped that emptying the uterus would release traction on the bowel and releve the obstruction. It should be emphasized that in the presence

of an enlarged uterus with marked distention or following a cesarean section, it would have been imperative in this instance to do only an enterostomy, which is at times successful, but nevertheless a most unsatisfactory procedure

A carbon diovide combining power three hours after the convulsions was 60 volumes per cent. Since the patient was not on intravenous fluids and actually was washing the chlorides out of her stomach, it is most probable that the convulsions were due to alkalosis. Dehiscence occurred in the face of low plasma proteins and was not unexpected. The patient also developed a thrombophlebits although she was out of bed relatively early and was moved throughout her illness. Of importance in evaluating this complication, it may be said that the patient received intravenous fluids through a vein on the dorsum of the left foot.

Discussion

From the surgical point of view, intestinal obstruction is respected as a very serious abdominal emergency The mortality is still very high but lower than it was prior to modern emphasis on suction decompression, hydration, and mineral and protein balance One of the basic principles is to delay operation, if at all feasible, to restore the patient so that she may be able to withstand surgery A well-established corollary is that sudden decompression by operation in a sick patient with intestinal obstruction is very dangerous With the release of pressure in the bowel lumen, the flow of blood fluids is suddenly increased into the tissue spaces This is an important factor in the rapid appearance of shock in the postoperative period

In high obstructions, the loss of fluids and minerals by vomiting is most serious Replacement by saline solution will enable the patient to sur-In low obstruction the mechanical vive longer effects of distention on the bowel are more important It may be stated that most of the air found in the bowel normally or in the presence of obstruction is swallowed atmospheric air aspiration of this air by gastric tube may afford remarkable relief of distention Further along, the obstruction is marked by distended loops which contain much more air than fluid Only in a closed loop is the gas produced by putrefaction or diffusion from the blood a major factor main hazards from this distention are venous return obstruction, jeopardy to bowel viability, and loss of plasma from the circulatory volume It is not unusual to wait twenty-four to thirty-six hours for the favorable effects of decompression and then to operate

Slemons and Williams believe there are no definite rules for handling the pregnancy, since many variable factors must be considered ¹² With advanced pregnancy, emptying the uterus

may be necessary to secure proper exposure of the pelvis. A draining enterostomy wound is undesirable in anticipation of a uterine operation Obstruction during pregnancy has a maternal mortality of 40 per cent and a fetal mortality of 65 per cent. In Larson's case, immediate operation was performed successfully with uneventful convalescence and birth five weeks later of a normal child. 13

Each patient must be individually appraised Whenever possible, a Miller-Abbott tube should be started, as well as intravenous fluids, immediately on admission Mercury in the rubber bulb will usually speed its passage into the duodenum after which it may be inflated with air Laboratory studies should include a determination of the blood protein and chloride levels Ovygen may be administered as the transfer of oxygen and carbon dioxide from the bowel is accomplished with greater ease than that of atmospheric nitrogen If, by all means available, a closed loop or gangrenous loop is not thought to be present, a further period of decompression with the tube should be A large percentage of patients will not need surgery subsequently

With a small uterus, the pregnancy may be disregarded However, in late pregnancy, most serious consideration should be given to emptying the uterus first, providing gangrene of the bowel is not present. It is proper to assume that with the uterus empty an incidental case may be relieved of mechanical obstruction in addition to the rare case of pregnancy ileus. Postoperatively, intravenous therapy includes protein, chemotherapy, and antibiotics, to be used as indicated

Summary and Conclusion

A case of intestinal obstruction complicating a seven months' pregnancy is reported in which labor was induced with the Voorhees bag followed in twelve hours by successful surgical relief without mortality

Intestinal obstruction associated with pregnancy is an infrequent but serious complication with a high fetal and maternal mortality

The use of the Miller-Abbott tube with suction and concomitant efforts to improve the general condition of the patient before operation, or to avoid operation, is imperative

Evidence of gangrene of the bowel or a closed

loop precludes delay

Early in pregnancy the size of the uterus may be disregarded. However, with a large uterus, induction of labor should be given serious thought. Proper therapy should successfully avoid infection.

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SHOULD CARDIAC PATIENTS BE PERMITTED TO TRAVEL BY AIR?

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BECAUSE of the increasing popularity of air travel, the family physician is frequently called upon to advise his cardiac patients as to whether it would be safe for them to travel by air. From a military aviation medical stand point, the altitudes at which commercial air liners fly are considered to be free from any serious hazards. In military aviation, however, one is dealing with selected healthy, young individuals who are physiologically adaptable to such comparatively minor environmental changes, which, on the other hand are apt to produce quite serious effects in individuals with disturbed cardio ascular function.

Most commercial airliners fly at altitudes of 8,000 feet or less but may under certain, sometimes unpredictable, circumstances go up as far as 10,000 and even 12 000 feet The USAAF set the upper limit for flying without the use of oxy gen equipment at 10,000 feet, except for brief periods of time At this altitude, even young, healthy individuals will show a drop in arterial oxygen concentration of about 10 per cent, with definite physiologie effects This moderate degree of anoxia resulting from flying at altitudes of 8 000 to 12,000 feet, which noticeably impairs the performance of military flight personnel would probably not even be noticed by the majority of airline passengers, especially since it is frequently associated with definite euphoria. It is concerv able, however that patients who suffer from coronary insufficiency may under these conditions experience a degree of myocardial anoxia that will impair heart function seriously

The "anoxia test," recommended for the diagnosis of coronary insufficiency is known to have brought on severe anginal seizures and is, therefore, considered too dangerous for routine use by many cardiologists. This 'anoxia test

consists in having the patient breathe a mix ture of 10 per cent oxygen and 90 per cent introgen for about twenty minutes. The breathing of such a 10 per cent mixture is equivalent to flying at an altitude of 18,000 feet. Ambient air at an altitude of 10 000 feet would be equivalent to a gas mixture containing 14 per cent oxygen. Continued exposure to this atmospheric pressure should be considered just as dangerous to persons with cardiac disturbances as the 'anova test' because of the time element.

Although the physical activities of an airline passenger are minimal, the added oxigen requirements, given by such activities as eating dinner on board the plane or going to the wash room, may possibly increase the danger addition to coronary insufficiency, there should be also an impairment of oxygen absorption, as in emphysema, thoracic deformities, pulmonary hypertension, respiratory disease, etc. duced oxygen carrying power of the blood, the danger of severe myocardial anoxia would be even greater Another important factor may be the apprehension and nervous tension which so many air passengers exhibit, especially when flying for the first time and often associated with hyperventilation, air sickness, etc.

Two methods for the prevention of anova at high altitudes are available at present, namely, oxygen-breathing equipment and cabin-pressuri sation. If oxygen equipment were available to airline passengers for continued use, this would remove most of the dangers of altitude. At the present time, however, oxygen equipment, if supplied at all on airliners, is available for intermittent use only, which would be insufficient. Moreover the use of such equipment requires preliminary instruction and is highly uncomfortable. It is very doubtful whether it will ever en-

joy great popularity with civilian airline customers

"Cabin-pressurization" is, at least in theory, the far more practical method. Its principle is, essentially, the compressing of the "thinned-out" air of altitude, to approach as nearly as possible the atmospheric pressure of air at ground level There are, however, structural limitations to withstanding more than a certain amount of "differential pressure" in the aircraft engineering has accomplished a great deal in trying to overcome these technical obstacles, but, to my knowledge, the commercial airliner that can give its passengers "sea level comfort in the stratosphere" is yet to be built In practice, these present limitations affect the altitude at which an airliner can cruise, rather than the safety of its passengers. For people with impaired cardiovascular function, however, cabinpressurization in its present state of development may represent a considerable source of danger

An aircraft flying at a certain altitude where human life would be impossible without the use of oxygen-breathing equipment can be "pressurized down" to a "cabin altitude" of, let us say, 5,000 feet, where pilot and passengers can exist comfortably and safely without additional oxygen. Should this certain altitude be exceeded, however, the "cabin altitude" may rise to 10,000 feet or more, with the same hazards we encounter in nonpressurized aircraft at such actual altitudes.

Another danger is that of "explosive decompression," ie the sudden release of cabin pressure through a structural defect in the cabin wall This danger is real enough, as two recent accidents on transatiantic airliners showed these conditions the passengers would be rather suddenly exposed to the extreme cold and low oxygen pressure at altitude Although this pressure drop may under certain circumstances take place more gradually, and although the pilot can always dive for safer altitudes, the anoma produced in the passengers during the time-lag before such safe altitude is reached, plus the excitement caused by the emergency, may be enough to produce in some individuals severe myocardial damage

For these reasons, it would appear that caution is indicated when we advise patients with coronary artery disease regarding air travel, even though we know of many cases where such patients have traveled by air without any apparent ill effects

The same caution would be in order for all patients who show noticeable degrees of impaired oxygen absorption, i.e., where there is dyspnea, reduced vital capacity, pulmonary congestion, cyanosis, etc., whether due to left ventricular failure, mitral disease, congenital defects, kypho-

scoliosis, emphysema, or other causes In some of these patients, the arterial oxygen concentration may already be dangerously low, in spite of subjective well-being, and any further reduction should probably be avoided. On the other hand, there does not seem to be any reason why patients with well-compensated valvular lesions, and even well-digitalized slow fibrillators, should not be permitted to travel by air, just like any normal person.

Cardiacs with associated gastrointestinal disturbances should be warned that the expansion of gases under conditions of reduced atmospheric pressure may cause them considerable distress which can, to some degree, be prevented by avoiding "gas-forming" foods for forty-eight hours before flight. It is also conceivable that such distension may originate vagovagal reflexes whenever such a tendency exists. Therefore, where such mechanisms may play a part, as in certain disturbances of rhythm, we may be induced to administer atropine as a precaution

Patients with disturbances of conduction should probably be considered with the same degree of caution as those with conorary artery disease, particularly where there is a history of Adams-Stokes' attacks or any other form of syncope

Cardiac patients with tendency to any form of motion sickness will probably have little desire to travel by air. Air sickness can be prevented, however, in most cases with hyoscine hydrobromide, 1/100 of a grain by mouth, one hour before flight and again at take off, to be repeated if necessary, this may or may not be supplemented with a barbiturate. Hyoscine is a most effective drug, and there are few, if any, contraindications to its use. It also serves to combat the apprehension so many people experience, particularly on their first flights.

Summary

An attempt has been made to outline some of the dangers confronting cardiac patients who travel by air. The opinion has been expressed that for some types of disturbed cardiovascular function, travel by air can have serious consequences, while for other cases it may be perfectly harmless.

The advice given to a cardiac patient should be based on evaluation of the individual patient's cardiovascular status, with particular attention to the relative sufficiency of his coronary circulation and the adequacy of his pulmonary gas-exchange and oxygen-carrying power of the blood. The writer is aware of the fact that few cardiologists share his concern about these alleged dangers.

COMBINED GENERAL AND LOCAL ANESTHESIA FOR VAGINAL DELIVERY

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TT IS admitted that the pain and apprehension Lassociated with the second stage of labor should be alleviated. No one method however has been completely acceptable There are avid proponents of practically all of the popular means of pain control and each cites valid arguments as to why his particular method is the procedure of choice

It is not the purpose of this paper to enter into this controversy. The authors merely wish to present a routine which has worked well in their hands in over five hundred vaginal deliveries

The entire project started during the war years when the shortage of both intern and nursing personnel was acute Before long it became apparent that the delivery room anesthetists in the various institutions were definitely not as experi enced as their predecessors. It had been our custom before this period to use nitrous oxide oxygen, and if necessary ether for almost all delivenes. The anesthesia was induced before operative vaginal delivery and continued until after the repair of the episiotomy the above routine was used by approximately 95 per cent of the obstetricians of the four insti tutions at which our patients were delivered Most obstetricians even today are completely indifferent to local anesthesia

There is no need to repeat in detail the disad vantages of nitrous oxide oxygen and ether anes-Uterine relaxation postpartum hemor rhage anesthetized babies disorientation vomit ing with aspiration pulmonary complications etc have all been described fully There is one great advantage however which cannot be disregarded The average patient wishes to escape completely, and general anesthena does give sleep and the desired relief

With the deterioration of anesthesia personnel the di advantages of general anesthesia were emphanized, and pudendal block was substituted The routine used was the standard one described by Griffin Sheldon Bunim and others 1 3

The advantages of local block were quickly apparent and most impressive These have already been noted in detail by Greenhill . However, three great deficiencies had to be taken into account

I The patients complained rather bitterly about the pain of the needle insertion especially when the anesthetic solution was being deposited in the upper labin and into the region of the ischial spines

- 2 The pain of the uterine contractions was not alleviated Most patients thought that the doctor was not helping them as much as he could or should
- Many felt and objected to the pull of the forceps even though the actual pain was blocked In their semiconfused state resulting from previous analgesia, the tugging of the forcers was sufficient stimulus to cause marked excitement and protestation in a certain percentage

Postpartum conversation with these patients revealed that the average private patient was not too happy about pudendal block especially if she met another woman who told her the glones of a general anesthesia, going to sleep and remembering nothing

It was felt however, that the advantages of local anesthesia could not be disregarded, especially during the repair of an episiotomy was decided therefore to use a combined tech me that would utilize the advantages of each The following was evolved

Method

When delivery is anticipated, the patient is placed on the delivery table and the routing preparation completed With each contraction she is given a mixture of 85 per cent nitrous orde and 15 per cent oxygen for the duration of the She is encouraged to bear down

If the delivery is to be spontaneous, the lower labia fourchette and perincum are infiltrated with 0 5 or 1 per cent processes. Approximately 15 to 20 cc are used for this and an additional 10 cc are used on each side in the levators to facilitate relaxation. The needle is inserted while the patient is getting the gas mixture dur ing a contraction If necessary the gas-oxygen mixture is prolonged about one minute to com plete the infiltration

At the time of delivery of the head, the general anesthesia is pushed if necesary, but generally the amount of gas needed in relation to the per centage of oxygen is less than when procaine is not used. It is rarely necessary to produce cyanosis to get results. An episiotomy is performed if indicated, at the time of crowning

Immediately after the delivery of the head, the anesthesia is stopped, and the mother is given straight oxygen Within one or two minutes the patient is awake

After the delivery of the placenta, the perineotomy is repaired under the effects of the procaine. The patient is assured that novocaine has been injected and she will feel no pain.

When an outlet forceps is anticipated, the exact procedure outlined above is carried out. Before forceps are applied, however, the patient is anesthetized with the general anesthesia. First plane induction is adequate. As soon as the head is born, the anesthesia is discontinued. In the average outlet forceps case the anesthesia time is three to five minutes instead of the customary fifteen to forty minutes of second or third stage anesthesia. Our depth of anesthesia is extremely light because of the perineal infiltration.

If a low or mid forceps operation is contemplated, a complete pudendal block is done. Gas is used to cover the painful deep insertion of the needle in the area of the ischial spines. It is felt that the greater relaxation and the greater area of nerve block justifies the additional complexity of pudendal block. Also, less general anesthesia is needed.

Except for a few refinements of technic, there is certainly nothing new in the method advocated It has, however, eliminated the common complaints that obstetricians have had against local block of the perineum. Using the combined routine certain advantages will be apparent

- 1 No deeper general anesthesia than first plane is necessary
- 2 The oxygen percentage is high so that asphyria of the newborn and mother is rare
- 3 The amount of general anesthesia given is minimal Usually, three to five minutes is the maximum duration
- 4 The length and depth of general anesthesia makes the administration relatively safe in inexperienced hands
- 5 The patients are satisfied because they have been relieved
- 6 The patients are not as ill postpartum from the anesthesia
- 7 Blood loss was definitely less, both from the uterus and from the episiotomy wound
 - 8 Pulmonary complications were minimal
- 9 The patients were awake and cooperative both in the delivery room postpartum and when put to bed in their own rooms
 - 10 Placentas separated more easily

Episiotomies were no more painful postpartum, and no delay in healing was noted. In the 438 episiotomies in this series, eight showed a moder-

ate amount of separation of the skin, and two broke down completely. This 2 plus per cent incidence of infection compares favorably with other series in which general anesthesia was used. In both cases of complete wound disruption there was prolonged labor and putrid lochia. The technic of repair of the perineotomies was 00 or 000 chromic with interrupted sutures.

No special knowledge is needed to do a perineal block, and a pudendal block is simple after a brief review of basic anatomy. The physician who will take the time to do a local block will be amply rewarded by the fewer obstetric emergencies he will encounter as a result of profound general anesthesia, and he will also have time to repair the episiotomy leisurely and with better surgical technic. The block lasts from forty-five minutes to one hour

The 500 patients reported were all private This was purposely done, because this type of patient generally demands more relief and their reactions can be more accurately evaluated. The women delivered by the combined method seemed satisfied. At no time did they appear resentful about the so-called callousness of their obstetricians to their supplications for relief at the time of imminent birth of their babies. Some expressed delight about seeing their offspring soon after birth and being reassured by their cries.

All of the patients were amply premedicated with demerol-scopolamine and/or barbiturates Even with this, however, it was definitely felt that further help, other than local block, was necessary in order to give adequate relief from the distress of the second stage

Conclusion

Greenhill states, "The most important one is the operator 'He must first convince himself that local is safest and simplest". The authors agree with the above, but are not convinced of the adequacy of local anesthesia alone. With the combined method, one has all the advantages of local anesthesia plus a satisfied patient. It is our contention that a satisfied patient is a most important part of medical practice.

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PNEUMONIA IN THE SMALL GENERAL HOSPITAL

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PNEUMONIA in its various forms has consti-tuted one of the major therapeutic problems confronting the physician. The disease was described by Hippocrates and Aretaeus in ancient times, but until the twentieth century and, in deed, until the past two decades, very little sig miscant progress has been made in the treatment of this serious emergency The pneumonia patients of Austin Flint and Sir William Osler received treatment nearly as efficacious as that which was accorded our patients in the 1920 s and the early 1930's. Prior to the development of type-specific antipneumococcus serum had been no significant advance in the treatment of pneumonia Certain refinements in the supportive management of the disease such as the use of oxygen, appeared However since antipneumococcus serum appeared rapid advances have been achieved, notably with the various sulfonamido derivatives and, more recently with penicillin.

The great reductions in the mortality rate in pneumonia since the development of potent specific agents is well known. From an alarming mortality rate twenty years ago, progressive reductions have been attained until today the discase is little feared and even is regarded with complacency by the general public as well as by some of the medical profession.

Numerous well-documented reports have been published in this regard. However nearly all of these have originated from the larger medical centers. This survey was prompted by a desire to analyze the results in pneumonia in the small general hospital during the period when most of the improvements in the therapy of pneumonia have been made. Trends in the problems of hospitalization of cases of this disease also were observed.

For purposes of this study, all cases admitted to the Wyoming County Community Hospital for treatment of a primary diagnosis of pneumonia were included. No distinction was made between the lobar and bronchial forms, and all cases were included regardless of cause, with the exception of purely secondary infections such as post-operative pneumonias, those occurring secondary to trauma, and strictly terminal infections. The study therefore, includes the bacterial forms of the disease as well as the more recently described viral or atypical varieties.

Table 1 shows the number of cases of pneu

monia per year from 1927 to 1946 inclusive with the number of fatal cases per year and the mortality percentage per year. It will be observed that the mortality percentage showed no appreciable improvement until the use of antipneumococcus serum became common in 1937 mittedly, the number of cases per year was too small to be statistically significant, but the results were characteristic of the period in question Serum was first used in the Wyoming County Community Hospital in 1934, but its use was quite rare until specific sera for all of the known types of pneumococci became available to us in 1937 Marked reduction in the mortality per centage then occurred, and this tendency has continued, although less precipitously through More impressive still are the mortality figures for the five-year periods demonstrated in Table 2 A progressive, significant decrease in the mortality percentage has occurred in each period It is significant to note that the mortality rate for 1946 was the lowest recorded in this hospital and it is to be hoped that this is indicative of further reduction to come

TABLE 1 —PREUMORIA MORTALITY BY FIVE-YEAR PERIODS

Period 1927 to 1931 1932 to 1935 1937 to 1941 1942 to 1945 Total	Number of Cases 63 118 406 292 879	Number of Deaths 23 35 63 31	Mortality Percentage 36 50 29 66 15 51 10 61

TABLE 2.—PREUNONIA CASES PER YEAR, NUMBERS OF FATALITIES, AND MOSTALITY PERCENTAGE

FATALITIES, AND MORTALITY PERCENTAGE								
Number Number of Mc Of of Mc Year Cases Deaths Per	ortality centage							
1927 7	5 00							
1925 13 5 5	8 46							
1929 21 7	13 13							
1930 15 K 9	3 33							
1931 7 9 7	iš 66							
1932 14 2	4 28							
1933 23 7 3	0 43							
1934 24 8	3 33							
1935 38 11 8	8 94							
1930 19 7 9	6 84							
1937 60 10 1	6 66							
1938 104 24 4	3 07							
1939 105 19 7	1 18							
1940 68 6	9 90							
1941 71 10 1	4 08							
1942 58 5	8 62							
1948 63 9 1	4 51							
1944 B1 10 1	. 34							
1945 85 3	8 57							
1946 56	7 14							
Total 879 152 1	7 29							

ł

1

were then analyzed and the mortality rate calculated for each. All cases which did not receive specific therapy were grouped under the heading of "Supportive and Symptomatic Treatment". The remaining groups were the cases treated with serum, those treated with the sulfonamides, those treated with a combination of serum and sulfonamides, those treated with penicillin, and finally, those treated with penicillin and one of the sulfonamides together

The results with the various forms of therapy

The mortality rate encountered with each form of treatment is indicated in Table 3. It will be noted that the best record was obtained using penicillin alone. The higher mortality where penicillin and the sulfonamides were used in conjunction is probably explained by the fact that this method was often reserved for the more critical cases.

TABLE 3 —PREUMONIA MORTALITY ACCORDING TO TREAT-MENT REVDERED

Treatment	Number of Cases	Number of Deaths	Mortality Percentage
Supportive and symptomatic	316	86	27 21
Serum	82	12	14 63
Sulfonamides	381	43	11 28
Serum and sulfonamides	38	5	13 15
Penicilin	35	2	5 71
Penicillin and sulfonamides Total	27 879	152	14 81 17 29

It was noted that the number of cases per year was very small during the first several years covered by the survey A correlation of the total number of patients admitted to the hospital per year and the number of pneumonia cases admitted per year was then made Table 4 shows the number of cases of pneumonia per 1,000 hospital admissions for each of the years in the twenty-year period. Until the advent of specific therapy, the number of pneumonia patients

TABLE 4 --- Preumonia Patients per 1 000 Hospital

	110,41001		
Year	Hospital Admissions	Pneumonia Patients	Rate per 1 000
1927	879	7	7 95
1928	944	13	13 77
1929	1 235	žĭ	17 00
1930	1 114	15	13 46
1931	1,370	7	5 10
1932	1,370 1 331	14	10 51
1933	1 482	23	15 51
1934	1 779	24 38	13 49
1935	1 956	38	19 42
1936	2 062	19	9 21
1937	2 300	60	26 08
1938	2 544	104	40 88
1939	2 853	105	36 80
1940	2 837	66	23 26
1941	2 849	71	24 92
1942	2 978	58	19 47
1943	3 063	62	20 24
1944	3 030	81	26 73
1945	3,216	35	10 88
1946	3 447	56	16 24
Total		879	

hospitalized was small, undoubtedly due to the fact that the hospital had little to offer other than somewhat improved supportive therapy and nursing care. Frequently, the patients were moribund on admission

In 1937 and 1938, serum therapy was in vogue.

and hospitalization became more common be-

cause of the difficulties attendant upon the administration of the serum at home. Since the sulfonamides and penicilin have come into wile usage, hospitalization of pneumonia patients has decreased because of the frequency with which these agents are employed in the home. Thus, the trend to more frequent hospitalization of pneumonia patients, which became most pronounced in 1938 and 1939, has now been reversed, and the past several years have shown a progressive decrease in the proportion of pneumonia cases to total patients admitted An intensive educational program regarding pneumonia was sponsored by the New York State Department of Health in 1937 and 1938, and, without doubt, this was responsible, to some degree, for the high hospitalization rate during the ensuing two years accurate analysis of the number of pneumonia cases treated in the home would be most difficult, because it has been observed that it is a common practice to start penicillin or one of the sulfonamides immediately after an initial chill and fever and before the classic symptoms and signs of pneumonia become apparent The improved methods of treatment of pneumonia are, therefore, of great economic importance, in that considerable hospitalization is avoided. This situation can also be considered to tend to alleviate somewhat the overcrowding which exists in so

many hospitals today In studying the results for the year 1946, it was noted that only one case of the 56 treated failed to receive penicillin or sulfonamide therapy Although not indicated in the statistics, a number of these cases were of the primary atypical variety A specific effect was not to be expected in this disease, but it was hoped that antibacternal therapy would lessen the frequency of complications and secondary infections and indirectly influence the morbidity and mortality That this may have been of some benefit is indicated by the exceptionally low mortality rate for the year and the fact that the average age of the four patients who succumbed in 1946 was seventysix and five-tenths years

On the other hand, the fact remains that the mortality rate in 1946 was 7 14 per cent. A disease which involves a hazard of this magnitude is not to be considered innocuous, and the medical profession has the responsibility of striving for further improvement in the therapy of pneumonia. Perhaps, also, the use of potent

specifies has fulled us into a sense of false security where full advantage is not taken of the acknowl edged valuable adjuvant forms of treatment such as oxygen where indicated, and judicious nursing care. However it is to be noted that the young est patient in this series to die of pneumonia in 1946 was seventy four years of age attesting to the wisdom of Sir William Otler who stated Preumonia may well be called the friend of the aged "1

Summary

1 The annual mortality due to pneumonia for the past twenty years in the small general hospital has been analyzed

The annual mortality percentage has been found comparable to the generally accepted rates for the years in question. A remarkable decrease in the mortality rate has occurred since the use of antibacterial agents began

The results with the various forms of treatment were studied and it was observed that the most favorable results were obtained with penicillin although it is possible that combined forms of treatment which were reserved for the more critical cases may actually be more effica-CIOUS

- A notable increase in the frequency of hospital admissions for treatment of pneumonia was observed during the first few years during which specific therapy was available and especially when antipneumococcus serum was in A corresponding decrease has occurred since the sulfonamides and penicillin came into wide usage The economic and hospital ad ministrative implications of these trends has been considered
- Continued reduction of pneumonia mor tably is called for with emphasis upon the supportive forms of therapy

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INTERNATIONAL CONFERENCE ON POLICHMELITIS SCHEDULED FOR JULY

The National Foundation for Infantile Paralysis of the United States has announced that it will celebrate its tenth anniversary by sponsoring the First International Poliomyelitis Conference to coordinate and evaluate the last decade of progress that medical science has made in the study of the disease.

According to the aunouncement it will be

the first time that information on poliomyclitic its treatment and research has been exchanged inter nationally on such an extensive basis. It is expected that the conference will bring together the world a outstanding laboratory and clinical authori ties on poliomyelitis

The meeting will be held July 12 to 17 at the Waldorf Astoria Hotel in New York City

THE BLOOD BANK SITUATION

It is learned that recently the American Red Cross has undertaken a National Blood Bank Program designed eventually to provide blood and blood deriva fives to the entire nation without charge for the products. As is usual in matters where national tation of medicine is in view, the figures are astro-nomic. The projected plan is to spend \$5,000,000 to start the program and \$20,000,000 annually, it is reported that 3,700,000 pints of blood must be obtained within the next year—one pint for every 35 Americana

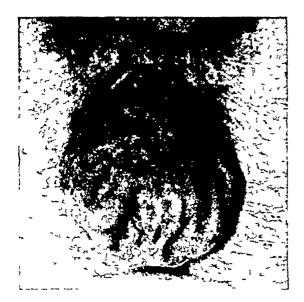
The American Red Cross while not politically dominated, operates with government sponsorship not with tax money but with public subscription The alletment of blood and its products by the American Red Cross would ultimately lead to the effect of having the Rod Cross practice medicine. The transition from this arrangement to state medi cine could become an imminent danger

The physicians who operate the blood banks of hospitals and communities have formed an associ atton The association is composed of institutional and individual memberships. Their objective is to ool their knowledge and influence and to render usoful and adequate service. It seems fitting in the interest of good medicine and the ultimate welfare of the patient that operation of blood banks be kept in the hands of those who have it now and of this association

Medicine did not grow up to the magnificent cooperative effort it is now by the work of social planners and bureaucratic directives It is the work of physicians striving together for the common good. The needs are not too big for such cooperation, Government governs best which Jefferson said governs least.

-New Orleans Medical and Surgical Journal,

March 1948



Fic 1 Massive prolapse of rectum

and within three weeks sphincteric control had re-Follow-up examination in July, 1947, revealed no prolapse and complete continence

Case 4 -A 43-year-old man, a restaurant worker, was first admitted for prolapse of the rectum in The prolapse was said to have been March, 1945 present since birth A Lockhart-Mummery procedure for prolapse of the rectum was carried out, and the patient was asymptomatic for a period of five At this time the prolapse associated with incontinence recurred completely He was readmitted in September, 1946, and a Roscoe Graham procedure was carried out—The patient remained entirely well and was examined last in May, 1947

Case 5 -A 60-year-old longshoreman was admitted in May, 1947, complaining of prolapse of the

rectum of six months' duration and complete incon-In 1935, the patient was subjected to five operations elsewhere for fistula-in-ano resulting in complete incontinence without prolapse. In 1939, at Bellevue Hospital, a Wreden-Stone operation was performed and completely relieved his incontinence In December, 1946, prolapse of the rectum developed for the first time, and this was accompanied by incontinence He was subjected to the Roscoe Graham procedure, and when last examined, two months postoperatively, he was entirely well and continent

Comment

The five patients reported in this paper have been completely relieved of their rectal prolapse, and all have been entirely continent

There are two points which should be mentioned briefly First, although there has been no death or complication in this series of cases, the Roscoe Graham operation is a procedure of considerable magnitude, and, therefore, the patient must have careful preoperative preparation and expert anesthetic management Second, preoperative catheterization of the ureters is a useful guide for the prevention of mjury to the ureters while working deep in the pelvis

> 156 East 79th Street 55 East 92nd Street

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HAVE THE PEDIATRICIANS SUCCUMBED?

"Not all of us share the American Medical Association's philosophy of fear of socialized medicine," Dr John P Hubbard said in testifying for the American Academy of Pediatrics before a congressional committee in Washington on March 11 Hubbard, who appeared before the Senate Health Subcommittee to support S 1290, said further that "we know the time is coming when the government will have to support medicine in some degree want to be in a position to direct that support"

Dr Hubbard is director of the Study of Child Health Services of the American Academy of Pediatrics in Washington

March 29, 1948

Commenting on Dr Hubbard's testimony, the Shearon Medical Legislative Service in Washington said that "the latest organization to succumb to the lure of 'easy' Federal money is the American Academy of Pediatrics

"The Academy, asking for funds to train pediatricians and to bring about a better distribution of such specialists, proposed that Congress appropriate five million dollars to provide for grantsin-aid by the FSA in support of pediatric edu-

-Secretary's Letter, American Medical Association,

SHOCK IN ACUTE MYOCARDIAL INFARCTION

HARRY GREISMAN, M.D., 201d S. ZELMAN ROSENPIELD, M.D. New York CITY

(From the Medical Service of the Lincoln Hospital)

IN 1795, James Latta introduced into medical vocabulary the term "shock, describing a symptom complex he beheved to be inflammatory in nature." In the one hundred and fifty two years since shock has been studied in detail by numerous investigators and has been subdivided into many types. Harrison and Blalock divided shock into four basic types—neurogenic hematogenic or oligenic, vasogenic and cardiogenic—and this classification is universally accepted today."

Shock in acute myocardial infarction generally has been onlitted in discussions of shock in the literature. Bover in 1044 rovived interest in cardiogenic shock specifically, and he reiterated the view of Fishberg that shock in myocardial in farction results from a marked decrease in cardiac output '4' Wiggers has suggested the probable importance of cardiac failure as a sustaining factor, even in traumatic shock. Cardiac output measured in patients with myocardial infarction was shown to be diminished by Grishman and Master, Starr and Wood and others ** In experimental coronary occlusion Gross Mendlowitz and Schauer also showed a decrease in cardiac output to

Method of Study

During the first five months of 1947, all patients admitted to the medical service of the Lincoln Hospital with the clinical picture of acute my ocardial infarction were studied Cases without later electrocardiographic or pathologic proof of the diagnosis were discarded. From Datients in clinical shock, venous blood was obtained as soon after admission as possible and the specific gravities of the whole blood and plasma were determined after the copper sulfate method of Phillips et al. 11

Clinical shock was judged present when the patient presented the following picture grayish acrocyanosis often with purplish mottling of the skin cold extremities cold and moust skin superficial respirations, and a rapid small pulse Whenever possible venous pressure readings were taken on these patients at the same time according to the direct measurement method of Morita and von Tabora. 12

Results

Cases —A total of 57 patients were studied Of these, 31 (54 4 per cent) survived and 26 (45 6 per cent) died The high mortality rate as compared to other hospitals, is explained by the fact that this hospital is a municipal institution with an extremely active ambulance service Patients are seen early. For example, five patients (3.8 per cent) died an average of one and three-tenths hours after admission to the wards. Such patients rarely reach other hospitals and die before medical attention is obtained. Of the 31 patients who survived their infarction seven (22.6 per cent) were in shock, of the 26 who succumbed, 18 (69.2 per cent) were in shock on admission. Of the entire group, 25 (43.9 per cent) were in shock on admission.

Age—The youngest patient in the series was forty-one years old the oldest eighty-six. The average age was saxty two and eight-tenths years Thurty nine patients (68 4 per cent) were in the fifty-one to seventy years age group

Sex —There were 36 men (63 2 per cent) and 21 women (36 8 per cent) The latter were all in the older age groups

Color —There were 50 white patients (87 7 per cent) and seven Negro patients (12.3 per cent)

Location of Infarction—The infarcted muscle was localized as follows anterior, 31 (544 per cent) posterior 17 (298 per cent), and mixed 9 (158 per cent)

Blood Pressure Changes—During the first twenty four hours after admission these were conspecific. In 22 patients the blood pressure was elevated, in nine it fell to hypotensive levels and in 10 it remained at normal levels. A systolic pressure above 145 was considered elevated and a diastolic below 65 subnormal. In the 25 patients in shock the distribution was altered with seven leaving an elevated blood pressure five maintaining a normal one and 15 showing a hypotension.

Diabetes —Ten patients (17.5 per cent) had proved diabetes mellitus. Of this number nine were women and one was a man

Cardiac Decompensation —Twenty patients (35 I per cent) were in frank cardiac decompensation requiring digitalis and directics Of this group, 12 were also in shock (60 per cent)

Venous Pressure —Of the 25 patients in shock, the venous pressure was determined in 12. It was elevated (above 100 mm) in soven, all of whom were in cardiac decompensation within normal limits in one and subnormal (below 40 mm) in four patients.

Changes in Blood Dynamics—The specific gravities of whole blood and of plasma were de-

TABLE 1 -- INFECTION

	Number of		-Cause of Dea	ıth		
Type of Delivery	Cases	Sepsis	Peritonitis	Pneumonia	Preventable	Nonpreventable
Spontaneous	2	2				2
Low forceps	3	2		1	1	2
Mid forceps	1	1			1	
Cesarean section	13		12	1	12	
Craniotomy	1	1			1	1
Total	20	6	12	2	15	5

TABLE 2 - HEMORRHAGE

Type of Delivery	Number of Cases	Cervical Laceration	——Cause of I Atomy of Uterus	Death——— Retained Placenta	Placenta Previa	Preventable	\on preventable
Spontaneous Low forceps Vid forceps	2		1	1		2	•
Breech extraction Version	i i	1	,		1	1	
Cesarean Total	- 7	1	3	2	1	$\frac{1}{7}$	0

therapy if the cause is promptly recognized and proper therapy immediately instituted. The liberal use of blood, the early recognition of trauma, and the proper evaluation of atony of the uterus will save most of these cases

Heart Disease—Heart disease has now joined the time-honored trio, infection, hemorrhage, and tovemia, as a major cause of maternal mortality. There were five cases in our series, a mortality rate of 9 per cent. None of the cases was judged preventable. The important lesson to be learned from this small group is that medical management of the cardiac patient is the most important phase of her obstetric care.

Toxemia—The causes of the toxemias of pregnancy are not known so that, while they cannot be prevented intelligent prenatal care and proper management will, for the most part, obviate the occurrence of eclampsia. The success achieved in the treatment of the toxemias of pregnancy is in no small measure due to the early recognition and the prevention of more serious developments by terminating the gestation in the nonconvulsive state. There were five deaths (9 per cent) in our series due to toxemia, all occurring in eclamptic patients, and all judged nonpreventable.

Embolism —There has been a greater incidence than usual of pulmonary embolism as the cause of death This accounted for nine deaths, or 18 per cent In eight of the nine cases there were no clinical indications of thrombosis or venous involvement prior to the fatal accident, nor was there any evidence of infection during the postpartum period Death followed rapidly after the first clinical manifestations of massive pulmonary The remaining patient developed a embolism pelvic thrombophlebitis following a mid forceps delivery and on the thirty-first day, while out of bed, having "recovered" from the thrombophlebitis, expired from a pulmonary embolus

All of these cases were judged nonpreventable It is of interest to note that all the embolic phenomena occurred before the days of heparin, dicoumarin, early ambulation, and femoral vein lightness

Summary

A summary of the maternal mortality at the Bronx Hospital for the thirteen-year period between 1932 and 1945 is presented

In 30,568 cases, there were 57 deaths, a mortality rate of 0 0187 per cent. This low figure is due to the concerted effort of the staff of a well-organized hospital, as well as supervision and cooperation among the various departments.

Preventable factors were present in 24 cases, or in 43 per cent. It is here that everything possible must be done to safeguard the patient so that these preventable factors may be overcome. That such improvement can be made is shown in the figures for 1946 where, in 3,085 cases, there was seen a mortality of only two, or 6 per 10,000 cases 7

References

- I Davis VI E., and Gready T G Am J Obst. & Gynec 51 492 (1946) ² Frank C W and Kushner J I Am J Obst. & Gynec 21 708 (1931) ³ Kushner J Irving Am J Obst. & Gynec 32 874
- (1936)
 4 Idem New York State J Mep 40 194 (1940)
 5 Maternal Mortality in New York City New York
 The Commonwealth Fund 1933
- 6 US Dept of Labor Children's Bureau Chart r\1\141-4 1944
 7 Unpublished figures the Bronx Hospital 1946

I am indebted to Dr Meyer Rosensohn director of the obstetric service of the Bronx Hospital for his helpful suggestions and untiring interest in the preparation of this report. I am thankful to Dr A. B Tamis chairman of the Maternal Mortality Committee of the Bronx County Medical Society for permission to use the committee 8 reports

Case Reports

CUTANEOUS BLASTOMYCOSIS, NORTH AMERICAN TYPE

EMORY LADANY, M D , New York City

(From the New 1 ork Polyclinic Hospital)

NORTH American blastomycosis (Gilchrist s discase) is a distinct clinical entity chronic infectious disease caused by a specific agent Blastomyces dermatitidis, a budding yeastlike fungus. Two clinical types of the disease are recog nized the systemic type and the cutaneous type

The systemic type of the disease progresses fairly rapidly giving rise to grave symptoms and leads to death in the majority of the cases in a matter of

weeks or months.

The cutaneous type of blastomycosis is confined to the skin, forming ulcerative papillomatous lesions accompanied by occasional slight discomfort Cutaneous blastomy cosis rarely becomes systemic, and if recognized and treated early it responds to well-chosen curative measures. However neglected and extensive cases may run an extremely chronic course resisting all forms of therapy and remissions may be followed by relapses for several years.

Case Report

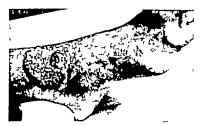
J. P., a 65-year-old Negro man, was referred to me for diagnosis on November 12 1946 He was complaining of slowly progressing warty and malodorous essons on various parts of his skin. The patient was admitted to the New York Polyclinic Hospital on November 16 where he remained until December 7 1946. His past history was essentially negative.

The first lesson of his present condition appeared on the ccupital region about two years ago while he was working in a junk yard in Lancaster Pennsyl vania. He was hospitalized twice each time for two weeks, and visited several private physicians during the past two years His treatment consisted of local applications of various ointments and solutions and he was taking 'drops for several months at a time without any favorable results.

Examination showed on the forehead a palmsized plaque with a serpiginous elevated and verru cous margin The center of the lesion was a plinble white scar On the lower border of this plaque ex tending to the bridge of the nose there was evidence of irregularly defined crust and scale-covered ulcera-tions. On the left forearm there was a similar but more acute lesion present (Fig. 1) The margin here more acute lesion present (Fig. 1) The margin here was sharply raised over the skin surface and showed papillomatous vegetations with many small abscences, while the center was depressed and consisted of scar tissue covered with a malodorous seropurulent exudate. Similar but smaller discrete annular and coalescing lessons, without central scarring were found on the left elbow on both hands on the right thigh, and on the dorsum of the left foot (Fig. 2) lesion last mentioned was about 2 inches in duameter and was raised half an inch above the skin surface



Showing lesions of cutaneous blastomycosis on the forehead and on the left forearm with elevated verrucous margin and central white



Lesion on the left ankle well raised over the skin surface and showing papillomatous vegeta tions with small abscesses.

TABLE 1 -INFECTION

	Yumber of		-Cause of Dea	th		
Type of Delivery	Cases	Sepsis	Peritonitis	Pneumonia	Preventable	Nonpreventable
Spontaneous Low forceps Mid forceps	2 3 1	2 2 1	12	1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 2
Cesarean section Craniotomy	13 1	1	12	1	12	1
Total	20	6	12	2	15	5

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Type of Delivery	Number of Cases	Cervical Laceration	Atony of Uterus	Retained Placenta	Placenta Previa	Preventable	Non- preventable	
Spontaneous Lon forceps	2 1		1	1		2 1		
Mid forceps Breech extraction Version	1 1	1	1		•	1		
Cesarean	i		1			1		
Total	7	1	3	2	1	7	0	

therapy if the cause is promptly recognized and proper therapy immediately instituted. The liberal use of blood, the early recognition of trauma, and the proper evaluation of atony of the uterus will save most of these cases.

Heart Disease—Heart disease has now joined the time-honored trio, infection, hemorrhage, and toxemia, as a major cause of maternal mortality. There were five cases in our series, a mortality rate of 9 per cent. None of the cases was judged preventable. The important lesson to be learned from this small group is that medical management of the cardiac patient is the most important phase of her obstetric care.

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5 Maternal Mortality in New York City New York,
The Commonwealth Fund 1933
6 US Dept of Labor Children's Bureau Chart
fMM41-4 1944

⁷ Unpublished figures, the Bronx Hospital 1946

The results of early treatment and destruction of the infectious focus should be far superior to any other known therapeutic measure. In advanced cases of the disease, skin tests are advisable and, if hypersensitivity is present desensitization with the specific vaccine abould be tried before large doses of lodides are given.

Summary and Conclusions

June 1 1948]

An unusually extensive case of cutaneous blastomycosis is reported in which direct examinations, cultures histologic examination skin test and complement fixation test confirmed the diagnosis cillin injections and various local applications suppressed the recondary infections but failed to in fluence the disease. Electrosurgery and cutaneous desensitization were tried

It is believed that the best results in the treat ment of cutaneous blastomy cosis are obtained by early recognition of the disease and by thorough electrosurgical destruction of the initial foci of the infection

30 East 60cm Street

I wish to express my gratitude to Dr. Norman Conant, of Ducked University who was kind enough to send me the break fraction test to Dr. Sidney A. Glastione of New York Polychiale Hospital for the histopathologic examination and preport, and to Dr. Riboda Benham of Columbia University and Dr. Frederick Reiss of New York University for their valuable aid in the cultural studies of this case.

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THE OCCURRENCE OF TUMORS AND LEUKEMIA IN MEMBERS OF FAMILIES OF PATIENTS SUFFERING FROM LEUKEMIA

LUDWIL GROSS M.D., and MICHABL L MATTE M.D. New York City

(From the Veterans Administration Hospital Bronx New York)

ON EXAMINING patients treated for leukemia at the Veterans Administration Hospital in Bronz, New York we have recorded several interesting cases revealing the occurrence of tumors in members of their families. Nineteen patients suffering from leukemia have been interviewed and 10 of them had a family history of either tumors or leu kemia. In addition a patient suffering from Hodg kin a disease was found to have a family record of lenkemia both his mother and grandmother having died from this condition

This was in a striking contrast to results obtained in interviewing controls consisting of patients suffer ing from conditions other than tumors or leukemia (such as hornia, appendicitis, pneumonia bone fractures etc.) Three hundred and one such control patients were interviewed as to the occurrence of tumors or leukemia among members of their families and only 12 per cent of them indicated either evi dence, or possibility, of a familial history of neoplasms.

Case Reports with Positive Family Histories

Case 1—22 year-old white male. Myelogenous kukemia Patient s brother 30 years old, had his right testicle removed in February 1946 for carci

Case 2-49-year-old white male Lymphatic keukemia. The patient s mother died of carcinoma of the stomach his sister died of carcinoma of the uterus.

Case 8 -40-year-old white male. Myelogenous culternia. The patient's mother died from breast cancer

Published with the permission of the Chief Medical Detector Department of Medicine and Burgery Veterans Administration, who assumes no responsibility for the opinions apprecised or conclusions drawn by the authors. The opinions appreciated at a later date as part of a study by L. Gross, Serported at a later date as part of a study by L. Gross, Perforts and Companies at the Veterans Administration Hospital, Broom, New York.

Case 4 -22-year-old white male. Myclogenous leukemia. The patient's mother died from breast

CARCCE Case 5 -30-year-old white male Lymphatic leukemia. The patient s maternal grandmother died

of breast cancer Case θ —23-year-old colored male Myelogenous leukemia. The patient's mother died of breast can-CFF

Case 7 —48-year-old white male. Myelogenous leukemia. The patient's father died of a recurrent malignant tumor of bone of lower extremity

Case 8 -56-year-old white male Lymphatic leukemia. The patient s father died of a sarcoma of right lower extremity

Case 9 - 10-year-old white male. Lymphatic leukemin Patient's brother died of cancer of the rectum.

Case 10 -31 year-old white male acute, myelogenous The patient's mother died of leukemia at 46 years of age.

Case 11 -23-year-old white male. Hodgkin s dis-The patient s mother and his maternal grand mother both died from leukemia.

Discussion

Anyone who has interviewed patients and asked questions concerning the cause of death of members of their families has probably noticed that it is you difficult to obtain any reliable information beyond one or two generations. The patient may know the answer concerning his or her own parents, perhaps also the grandparents, but a dependable answer beyond that limit is unusual. The collecting of data concerning familial incidence of certain conditions in man is therefore, difficult and at best only frag It also should be kept in mind that medi cal diagnosis was less accurate one or two generations ago than it is today and that not infrequently conditions such as internal tumors might have been un recognized.

causing the patient considerable pain and difficulty in walking. The lesions were covered with a thick seropurulent evudate and emanated a penetrating cadaverous odor.

Laboratory Findings—The examination of the urine gave normal values—The hematologic examination showed 76 per cent hemoglobin, 4,250,000 erythrocytes, and 1,070 leukocytes with 74 per cent polymorphonuclears and 26 per cent lymphocytes. The Wassermann and Kahn tests were negative

Microscopic examination of the pus from the small abscesses revealed large numbers of spherical and oval bodies with double contours, some of which showed a single bud, typical Blastomyces dermatitidis of Gilchrist (Fig 3) Cultures showed typical growths of Blastomyces dermatitidis on both Sabouraud's and blood agar mediums Skin test with 0 1 cc of blastomycin vaccine used intradermally gave a reaction over 1 cm in size after twenty-four hours Complement fixation test, using the diluted vaccine as an antigen, gave a positive reaction in 1 4 dilution and a doubtful reaction in 1 8 dilution



Fig 3 Blastomyces dermatitidis with the typical single bud as it appears in direct examination of the pus under high power magnification (Courtesy Dr Rhoda Benham, Columbia University)

Roentgenograms of the lungs and bones were essentially negative The histologic examination was reported as follows

Microscopic examination shows stratified squamous epithelium, showing very marked papillary hyperplasia and hyperemia, hemorrhage, edema, and polymorphonuclear and mononuclear infiltration of the connective tissue stroma. In some areas there is epithelial atypism. Spherical encapsulated organisms about 20 micra in diameter are seen in the small abscesses. Diagnosis. Chronic granulomatous infiltration of the skin. blastomycosis

The patient was presented on December 3, 1946, at the meeting of the Section of Dermatology of the New York Academy of Medicine, and the diagnosis was accepted

Treatment—In the hospital the patient received wet compresses, soaks, and baths of potassium permanganate and sulfathiazole powder and penicillin ointment locally, penicillin was administered intramuscularly, 2,400,000 units in seven and a half days. These measures cleared up the secondary infections, the lesions became dry and odorless, but there was no noticeable change in the shape, size, and elevation of the lesions. Considering the patient's strong skin reaction to the specific vaccine, desensi-

tization was started with an initial dose of 0 1 cc of a 1 100 solution of the vaccine to prepare the patient for later iodide and x-ray therapy

After he left the hospital, the vaccine injections in ascending doses were continued on an ambulatory basis, the patient receiving three injections weekly, which were combined with careful electrosurgery, using both the cutting current and desiccation. He showed encouraging progress. The lesions remained dry, and some of them became flatter and diminished in size gradually.

Comment

Advanced cases of cutaneous blastomy cosis offer a difficult therapeutic problem. Most authors feel that large doses of iodides combined with x-ray treatments give satisfactory results. However, the majority of cases reported were of several years' duration in spite of previous treatments, and relapses are common. Cures reported were accomplished after several months to several years of treatment, and even in the cured cases observation of the patients was not long enough in most of the cases to evclude the possibility of a later relapse.

The case reported here was of at least two years' duration and was treated intermittently with unknown quantities of iodides and different local applications without any evident beneficial effects. The patient's condition had grown steadily worse during the two years. He had widely scattered lesions all over his skin, and, although he had no evidence of systemic involvement, he was in a desperate condition. It may well be that the poor results of all previous treatments were due to the marked allergic hypersensitivity revealed by the positive skin test. He would probably have done much better on iodides after a completed desensitization, as in the cases of Martin and his associates 1.2

Penicilin injections did not seem to accomplish more in this case than the simple antiseptic local applications, namely, the clearing of the secondary infections. Cutaneous desensitization combined with electrosurgery seemed to give some promise, although, considering the extreme extension of the lesions, the total destruction of all infected areas seemed quite impossible by this method alone.

From the review of a number of case reports, it seems that there are no local applications which would have any curative effect on the lesions of cutaneous blastomycosis. Iodides, sulfa drugs, thymol, and arsenicals, alone or in combination with x-ray treatments, do not give uniformly good results in advanced cases of cutaneous blastomycosis. Since it is a local infection of the skin beginning with slowly progressing lesions at the portal of entry, the best therapeutic results may be expected from early and thorough destruction of the lesions by electrosurgery

Early diagnosis is, therefore, essential and may prevent years of misery for the patient. The disease is perhaps not quite so rare as formerly believed, and it should be kept in mind as a possibility in all cases of indolent ulcers of the exposed parts. The lesions are quite characteristic even in the early stages, and the microscopic examination of the pus is simple and can be performed by the general practitioner who will probably see most of the early cases.

The results of early treatment and destruction of the infectious focus should be far superior to any other known therapeutic measure. In advanced eases of the disease skin tests are advisable and, if hypersensitivity is present desensitization with the specific vaccine should be tried before large doses of lodides are given

Summary and Conclusions

An unusually extensive case of cutaneous blastomycosis is reported in which direct examinations cultures histologic examination skin test and complement fixation test confirmed the diagnosis. Ponidillin injections and various local applications suppressed the secondary infections but failed to in fluence the disease Electrosurgery and cutaneous desensitization were tried

It is believed that the best results in the treat ment of cutaneous blastomycosis are obtained by early recognition of the disease and by thorough electrosurgical destruction of the initial foci of the infection

30 Cast COTH STREET

I wish to express my gratitude to Dr. Norman Commt, of Dull University who was End enough to send no this visit of the visit of vis

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THE OCCURRENCE OF TUMORS AND LEUKEMIA IN MEMBERS OF FAMILIES OF PATIENTS SUFFERING FROM LEUKEMIA

LUDWIK GROSS M.D., and MICHAEL L. MATTE M.D., New York City

(From the Veterans Administration Hospital Bronx New York)

ON EXAMINING patients treated for leukemia at the Veterans Administration Hospital in Bronx, New York we have recorded several interest ing cases revealing the occurrence of tumors in mem bers of their families Nineteen patients suffering from leukemia have been interviewed and 10 of them had a family history of either tumors or leukemla In addition, a patient suffering from Hodgkins disease was found to have a family record of lenkemia both his mother and grandmother having died from this condition.

This was in a striking contrast to results obtained in interviewing controls consisting of patients suffer ing from conditions other than tumors or leukemia (such as hernia, appendicitis pneumonia bone fractures etc.) Three hundred and one such control patients were interviewed* as to the occurrence of tumors or leukemia among members of their families and only 12 per cent of them indicated either evi dence, or possibility of a familial history of neoplanna

Case Reports with Positive Family Histories

Care 1—22-year-old white male. Myelogenous rukemia. Patient s brother 30 years old, had his right testicle removed in February 1940 for carca

Care 2 -49-year-old white male. Lymphatic leukemia. The patient a mother died of carcinoma of the storage of th of the stomach his sister died of carcinoma of the

Case 3 -40-year-old white male Myclogenous leukemia. The patient s mother died from hreast CADCET

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Toron, be reported at a later date as part of a study by L. Gross, be reported by the control of the property of the pr

Case 4 -22-year-old white male. Myelogenous leukemia. The patient's mother died from breast cancer

Case 5 -30-year-old white male. Lymphatic leukemia. The patient s maternal grandmother died of breast cancer

Case 6 -23-year-old colored male Myologenous leukemia The patient s mother died of breast can

Case 7 --- 48-year-old white male. Myclogenous leukemia. The patient a father died of a recurrent malignant tumor of bone of lower extremity

Case 8 -50-year-old white male Lymphatic loukemia. The patient's father died of a sarcoma of right lower extremity

Case 9 -40-year-old white male Lymphatic leukemia. Patient's brother died of cancer of the rectum.

Case 10 -31 year-old white male. Leukemia. acute myelogenous. The patient s mother died of lcukemia at 46 years of age.

Case 11 -23-year-old white male Hodgkin a discase. The patient a mother and his maternal grandmother both died from leukemia.

Discussion

Anyone who has interviewed patients and asked questions concerning the cause of death of members of their families has probably noticed that it is very difficult to obtain any reliable information beyond one or two generations. The patient may know the answer concerning his or her own parents perhaps also the grandparents, but a dependable answer bevond that limit is unusual. The collecting of data concerning familial meidence of certain conditions in man is, therefore difficult and at best only frag It also should be kept in mind that medi cal diagnosis was less accurate one or two generations ago than it is today and that not infrequently condi tions such as internal tumors might have been un recognized

In spite of these difficulties, 10 of 19 patients (53) per cent) suffering from leukemia, were found to have a history of either tumors or leukemia in their families

Two different groups of families should be con-(a) Those in which certain insidered separately dividuals developed leukemia and other tumors, patients, suffering from leukemia, who indicated a history of tumors in their families belong to this group (b) Families in which more than one member developed leukemia Patients suffering from leukemia, and stating that some other member of their family also died from leukemia, belong to this second group

In our study we found that more than one half of the 19 leukemic patients interviewed had a history of tumors in their immediate families. In addition, two families were revealed in which more than one member developed leukemia Thus, in one instance (Case 11), the mother and grandmother of a patient suffering from Hodgkin's disease died from leukemia The mother of another patient (Case 10) died from leukemia, as did he

The control group consisted of patients suffering from conditions different from tumors and leukemia Three hundred and one patients (white males) suffering from various conditions, such as hernia, pneumonia, appendicitis, etc, were interviewed, no more than 12 per cent of these patients revealed a history of tumors among members of their families This was in a striking contrast to the high percentage of positive tumor histories among families of patients

suffering from leukemia The concurrent development of leukemia and various malignant tumors in man has been reported repeatedly 1-4 Much more often, however, it was observed that patients suffering from leukemia had a family history of tumors 5

Cases of leukemia developing in brothers, brothers and sisters, or in a child and one of his parents, have been recorded by several authors 6-18 Some of the authors were able to trace leukemia up to four successive generations in members of the same family 5 Such cases were striking, particularly in view of the fact that leukemia is a rather rare disease in man

Similar observations have been made in animals Thus, Lockau observed several cases in which the progeny of the leukemic cows died of leukemia 19 Czymoch reported 8 cases of leukemia developing in cow and daughter, another apparently healthy cow had 2 leukemic daughters and, also, a leukemic granddaughter, in other instances, 16 out of 20 offspring of the same bull, who eventually developed the same disease, 20 died of leukemia Veterinarians, as well as farmers, long have been aware of the fact that leukemia not infrequently develops in animals belonging to the same family 21 The occurrence of leukemia in successive generations of certain breeds of chickens, such as white leghorns, also has been Recent studies suggest that leukemia appears in descendants of certain inbred lines of chickens, whereas in nonleukemic families the birds remain essentially free from this condition 22 Analogous observations have been made in mice.23-27

The fact that, of our 19 patients suffering from

kemia in their families does not seem to be a mere coincidence The lack of our understanding, however, of the true nature of leukemia and tumors makes it very difficult at the present time to furnish a reasonable explanation of this curious phenom-

It appears worthwhile, nevertheless, to investigate in patients suffering from leukemia the possibility of a history of either leukemia or tumors in members of their families A positive family history may have, in certain cases, some diagnostic value event, the data thus obtained may prove of value to future research on the nature of tumors and leukemia

Summary

Nineteen patients suffering from leukemia and treated at Veterans Administration Hospital, Bronx, have been interviewed, and 10 of them were found to have a history of either tumors or leukemia in their families

In addition, a patient suffering from Hodgkin's disease was found to have a family record of leukemia, both his mother and grandmother having died from this condition Three hundred and one control patients were also interviewed, and only 12 per cent of them were found to have a history of cancer among members of their families

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PENTOTHAL SODIUM FOR SEDATION

E EMMA, M.D., and S. G. HERSHEY, M.D., New York City

(From the Department of Ancethesia, Beth Israel Hospital and New York University, College of Medicine)

OCCASIONALLY outside of psychiatric prac-tice the problem of providing sedation for the agitated patient can become an acute therapeutic emergency With few exceptions, the wide array of analgeme and hypnotic drugs ordinarily utilized in the course of medical and surgical practice serves safely and effectively Every now and then how ever circumstances develop in which the ordinary depressant drugs, short of dangerous overdosage are ineffective. This situation can become critical when continued restlessness and agitation may seriously threaten a patient's recovery The following case report in which the patient was successfully treated with pentothal sodium administered for its hypnotic rather than its anesthetic properties, illustrates this problem.

Case Report

The patient was a 50-year old white man admitted for anuria and left loin pain. In addition, a history of essential hypertension and peptic ulcer was obtained. The significant findings included blood pressure 190/110 monprotein nitrogen 64, left ranal calculus and nonfunctioning right kidney.

Two days after admission left urcterolithotomy was performed during spinal anesthesia. Within a few munutes following induction of anesthesia, the patients pulso and blood pressure were unobtainable. They returned to satisfactory levels in twenty minutes only after vasopressors and oxygen were administered. Operation was completed, and the patient returned to bed apparently in good condition. The postoperative course was not remarkable for two days when the patient suffered a sudden, severe hemorrhage from the operature site. Treatment for this was rapid and vigorous. The wound was oponed and packed without anesthesia at the bedside. Transfusion was started, lie was brought to the operating room anesthetized with cyclopropane, and a vessel in the left renal pedicle religiated. His condition seemed satisfactory although his blood pressure at one point dropped to 70/50 but rapidly roturned to a safer level with turther blood replacement.

Following this second procedure, the patient did poorly Urinary output remained low and the non protein nitrogen rose progressively to 109 The partially visible left kidney demonstrated a gross

infaret.

After seven days the patient became extremely reaties and uncooperative. On the eighth day restraints were required, and food or fluids could not be unccessfully given orally or parenterally. Ordinary sedative drugs including sodium luminal 0 2 Gm., choical hydrate 0 6 Gm and parallednyde 10 cs. in represented doses were completely ineffective.

Parenteral fluid and nutritional support, although critically needed, could not be maintained. At this point the patient was in a state of continuous physical and vocal overactivity. This was ascribed to the urenic state or possible mental deterioration following the two hypoxic episodes one, the period of hypotension during the first operation and

second during the period of hemorrhage preceding the second operation

At this time 1.5 mg of apomorphine were given intravenously without effect. This drug has been used successfully in other types of central nervous

system overstimulation 1

Thirty minutes later, sloop was induced with 6 cc. of a 2.5 per cent solution of pentothal sodium and was continued by means of a continuous infusion of a 0.1 per cent solution. A total of 1.0 Gm. of the the drug was so administered over a two-hour period. The patient was easily aroused within fifteen minutes and fully awake half an hour later. He remained quiet and cooperative for the following nine days without the necessity for repeating this procedure. Unfortunately his kidney function did not improve, and he died at the end of this time. Autopsy was not obtained.

Comment

The use of pentothal sodium to provide hypnosis, rather than the surgical anesthesia for which it was originally recommended, is not entirely new There are numerous references to comparable use in psychiatric practice. Again it is often employed in patients undergoing surgery during some form of regional anesthesia when such conscious patients become unduly uncomfortable or apprehensive? As described here, its administration to the post-operative patient who becomes excessively agitated or acutely psychotic is a somewhat different clinical application of this popular anesthetic agent.

Other methods of sedation in difficult circumstances should not be overlooked. Most popular is the intravenous administration of barbituric acid derivatives such as sodium amytal or pentobarbital, rather than the ultrashort acting members of the group Another technic is the retention enema of avertin or ether Paraldehyde and chloral hydrate also may be used parenterally Consideration, how ever should be given to the fact that retention enemas may be difficult to give and virtually impossible to have retained, and that most of these drugs once absorbed have to be detoxified and excreted. In such patients, with unbalanced fluid and nutritional status and functional or organic liver and kidney dysfunction these drugs may have unpredictable and deleterious effects. Once absorbed they cannot effectively be recovered and. therefore, lack a fineness of control so advantageous in a critically sick individual.

Pentothal sodium, because of its rapid effects, may be administered in dilute solutions with a degree of control comparable to that obtainable with inhalation anesthetics. Although it also must be detorified, there is considerable evidence to show that it is metabolized rapidly and is innocuous in regard to liver and kidney function. For these reasons, in addition to its potent hypnotic effects, it is suggested as a valuable aid in providing sedation in certain difficult, albeit infrequent, situations.

COL

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ILIAC BONE GRAFT TO FILL OSTEOMYELITIC DEFECT IN LONG BONES

Отно С Hudson, MD, Hempstead, New York

(From the Nassau Hospital)

DURING World War II a number of articles have appeared for and against grafting of bone defects in wounds associated with osteomyelitis

Knight and Wood advised a program of (1) thorough sequestrectomy and excision of the scar, (2) early split skin grafting and, finally, (3) bone grafting followed by the immediate application of a full thickness pedicle skin graft to secure healing of osteomyelitic cavities in bone. They state, "The first stage is that all nonviable bone and bone of questionable viability should be removed, and the fracture site should be saucerized so that granulation tissue will cover the bone surfaces. An attempt is made to preserve any union which may be present, but minimal fibrous union must be sacrificed. The wound is packed open and immobilized in plaster.

"Thus far, of the 23 cases reported, the wounds in all but two cases have healed entirely. Bone sepsis has been eradicated in all cases of the series, and, in all, the defects have been eliminated. There has been no sequestration of any of the clups and no roentgenographic evidence of osteomyelitis following the insertion of the bone chips,"

We wish to report two cases using this technic with excellent results in each case

We believe the use of cancellous that bone graft chips on good granulations covering bone ends and fragments is very similar to pinch skin grafting on granulating areas. The bone chips must be covered with good skin. This coverage is best obtained in the humerus or femur where muscle and skin are abundant. The wounds are closed loosely.

Case Reports

Case 1—J B, a woman aged 19, was in an auto accident on April 29, 1946 She received the following injuries—cerebral concussion, fracture of all transverse processes of lumbar vertebrae, explosion fracture third lumbar vertebra, separation of left symphysis pubis and sacrollac joint, fracture right external malleolus, and fracture of shaft of left femur—Closed reductions done on all injuries with

excellent restoration of fractures It was impossible to maintain the left half of the pelvis in position with traction on the femur. An open reduction was done with dual plating. An osteomyelitis developed with drainage. On December 14, 1946, the plates and all devitalized bone were removed. The medulary canal opened. The bone fragment ends were saucerized. There was union posteriomedially that was not disturbed. The wound was loosely closed.

On January 8, 1947, the wound was reopened, and the bed was covered with good red granulations. The entire defect was filled with iliac bone chips and the wound closed. Plaster spica was applied. Pencillin was given five days preoperative and postoperative. The wound healed. On June 5, 1947, all plaster was removed, and the x-ray showed excellent solid callus formation.

Case 2—J A, a 16-year-old man, was in an auto accident on June 4, 1946. He was injured in the left femur. An open reduction was done with plating. An osteomyelitis developed with nonunon On December 16, 1946, the plates and all sequestra were removed. The bone ends were saucerized. Wound was closed loosely. On January 8, 1947, the wound was reopened, and the entire cavity was found to be covered with good granulations. The cavity was filled with iliac bone chips, and the wound was closed loosely with immobilization in spica. Penicillin was given five days preoperative and postoperative. The wound healed. On June 19, 1947, the plaster was removed. The 'ray showed excellent solid callus formation.

This procedure during World War II had been proved adequate to handle a certain group of cases. These same cases occur in civilian practice, so the procedure is also useful

It is only good in young adults We do not feel that adults past middle age, where circulatory changes are occurring in extremities, can be handled by this method of treatment

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PRIMARY THROMBOSIS OF THE AXILLARY VEIN

BERNARD J FICARRA M D , Brooklyn, New York

(From the Surgical Service of St. Peter & Hospital)

PRESENT-day surgical literature displays an accentuated interest in vascular diseases and unusual syndromes encountered in clinical surgery In view of these facts, this present report of an unusual vascular entity may be of current value

Thrombophlebitis of the axillary vein is rarely seen. On various occasions it has been termed primary thrombosis effort thrombosis primary phlebitis, or effort phlebitis of the axillary vein The occurrence of thrombophlebitis in the axillary vein is such a rarity that its cause has not been definitely established. Well-developed men are the usual victims of this type of phlebitis The onset of the thrombous can be traced to strenuous effort of the arm most frequently used sudden exertion or un usual exercise may be the precipitating cause

Several theories have been advanced as to the cause of this particular type of thrombophicbitis. It was originally believed that a localized phiebitis secondary to sudden trauma of compression or stretching was the major factor. Some investigators have postulated an anatomic cause. Venous constriction by the costocoracoid ligament producing a disruption of one of the availary vein valves by sudden effort has been indicted. disruption initiates the inevitable thrombosis.1 The site of constriction lies below the humeral head against the subscapularis during abduction of the arm.

Infection itself is not the cause of this type of phlebitis. Many years ago spasm of the vein due to sympathetic irritation as the result of trauma was suggested as the major initiating factor 2. In view of our present knowledge of reflex sympathetic dystrophy the base etiology of this type of throm bosis perhaps may be elucidated on this basis 1

The pathology in the vein itself has been demon strated to be a true thrombosis One investigator at operation found no thrombons present only marked venous spasm ! However clinical and radiologic studies of the axillary vein in patients with this syndrome have revealed true thrombosis.

The symptomatology of primary axillary thrombophlebitis follows a similar pattern in all cases A history of prolonged use of the arm, sudden ex ertion, or maintaining one position for a long period of time is usual. This is followed by the appear ance of sudden painless swelling of the entire arm without a systemic reaction. No local inflammatory sums are noted. Initially the arm is symnotic and shows clinical evidence of edema. The axillary vein may be readily palpated When it is palpable the vein is tender and firm. With the development of a collateral circulation the superficial veins of the arm become prominent and the cyanotic hue disappears with the appearance of a dusky redness to the skin. The edoma subsides as the disease progreenes to the chronic phase, but the size of the af feeted arm remains larger than the normal ex

tremity, however. This residual disparity is the rule rather than the exception

Case Report

The patient was a 33-year-old ex G I who was seen for the first time on February 5 1947 He presented a history of two years' duration Following sudden muscular effort, he developed pain and swelling of the right arm and shoulder; the arm became eyanotic He was not incapacitated because of this situation and received no active treatment excepting penicillin injections. The past history was not significant, and he had always en-

joyed good health

Physical examination in February, 1947 re-vealed a well-developed, well-nourished robust man whose physical status was excellent excepting for edema of the right shoulder and arm The skin of the right forcarm and hand had a dusky red appear Pulsation in the arteries was ample right wrist was one luch wider than the left. right forcarm below the elbow and the right arm at the level of the biceps were two inches wider than the left The right axillary voin was not tender to palpation but was quite prominently felt. The superficial veins of the shoulder and right arm were moderately to markedly distended. Temperature of the right arm was not altered as compared to the left The patient had recently developed variouse veins of the right leg. This patient presented chronic primary thrombophlebitis of the right axil lary vein

He was treated with a course of five paravertebral sympathetic blocks on alternate days. Objec tive improvement in this chronic stage was not as beneficial as expected, which may be attributed to the chronic nature of the disease. However prior to treatment the patient was unable to perform tasks such as hammering or playing handball with out producing a marked increase in edema and causing excruciating pain shortly after the exertion of right arm activity. In this particular instance the patient developed an adequate collateral circula tion which in a great measure had compensated for his axillary vein thrombosis.

Treatment

Treatment of axillary thrombophlebitis as in many other vascular diseases is divided into conacryative (medical) or operative(surgical) Medical measures are usually the first to be initiated. This regime may include rest, elevation of the arm and the application of an Ace bandage. A light Unna posto cast may be effective in some cases servative treatment has the primary objective of reducing and preventing the edema. Heparin and dlcumarol have not been employed in this type of thrombophlebitis, because no serious complications such as embolism, have been known to occur

Surgical measures have been employed In severe cases incisions have been made in the arm to permit the escape of edematous fluid (similar to the Kondolcon operation) Resection of the involved venous segment with or without periarterial sympathectomy has also been advocated 2

In view of our increasing knowledge of the sympathetic nervous system, paravertebral block obviates the need for operative resection of the venous segment Nerve block to include the stellate ganglion has been an effective method of treatment The beneficial results may be attributed to the same factors producing the benefits of lumbar paravertebral block in treatment of thrombophlebitis in the lower extremities

The technic is not difficult to follow A cervicothoracic injection may be accomplished either by the anterior route or the posterior route popular of these procedures is the posterior route The patient is placed on his side with the head flexed and elevated on a pillow to prevent lateral compres-Wheals are raised 4 cm sure of the cervical spine lateral to the spinous process of the seventh cervical and first, second, and third thoracic vertebrae These wheals are placed opposite the lower border of the first four ribs Needles are then introduced perpendicular to the skin for about 5 cm distance the rib or transverse process will be encountered The needle is then passed under the lower edge of the rib and pushed in a downward direction at an angle of 20 degrees toward the midline until the lateral aspect of the vertebra is reached Before injection, aspiration should be carried out to determine whether or not a vessel or pleura has Ten cubic centimeters of 0 5 per cent novocame is injected at each site. In view of the fact that the stellate ganglion lies in a groove in the neck of the first rib in front of the first thoracic nerve, a Horner's syndrome often results, although the block may be successful without the development of this syndrome Increased warmth on the side of the injection is one of the signs indicating a successful block.

Prognosis

With adequate treatment, which includes paravertebral sympathetic block, the prognosis as to the return of functional activity is good in chronic axillary thrombosis The arm, however, rarely returns to its normal physiologic capabilities in comparison to the capabilities of the other extremity

In acute axillary thrombophlebitis, no serious complication, such as embolism, has been reported Reduction of swelling and early function occurs with several paravertebral sympathetic blocks

When the chronic stage has been reached without the benefit of early treatment, as in this case, the outlook is less favorable. Weakness and stiffness become residual disabilities in spite of treatment Exertion of any type initiates a recurrence of edema

When the disease has had a chronic nontreated course, the skin of the affected arm continues to have a dusky-red color At this stage paravertebral block has a transitory beneficial effect, and unilateral thoracic sympathectomy may be contemplated Sympathectomy should be advised only when a demonstrable, beneficial effect has been noted following paravertebral block.

Summary and Conclusion

A case is presented of chronic primary thrombophlebitis of the axillary vein In view of the rarity of this pathologic entity, the report is believed to be of interest. The treatment of choice is paravertebral sympathetic block. This conclusion is based upon our present knowledge of the relationship between the sympathetic nervous system and thrombophlebitis in vascular segments

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PENICILLIN LOZENGES MAY BE CURE FOR DIPHTHERIA CARRIERS

Encouraging results from penicillin administered locally in the treatment of carriers of virulent diphthema are reported in the March 27 issue of the Journal of the American Medical Association.

The author, Dr A. J Levy, Divon, Illinois, points out that, while this form of penicillin administration for diphtheria carriers is still in the experimental stage, the results of the 4 cases reported may serve "to further the study of the effect of penicillin administered locally in the treatment of diphtheria carriers."

It is believed that for acute cases as well as for the carrier state the parenteral method of penicilin administration is of little value

When penicillin was used locally in the form of lozenges and spray, it was found in this limited study to be successful in the treatment of carriers of virulent diphtheria within one week, and the patients remained free from diphthena even a year after the study was made.

-News Release, American Medical Association, April 2, 1948

USE OF PROPYL THIOURACIL FOLLOWING RECOVERY FROM THIOURACIL AGRANULOCYTOSIS

MAXWELL SPRING, M.D., New York City

(From the Bronx Hospital)

ONE OF the severe toxic manifestations of thiouracil therapy for hyperthyroidism is agranulocytosis. Morton reviewed all the cases of agranulocytosis and described two of his own.1 One patient died, the other following recovery from the agranulocytic state reacted again with a fall in the white cell count when thiouracil was reinstituted. Propyl thiouracil was introduced as a less toxic antithyroid compound. Up to the present time, Bartels has reported the only case of agranulocytosis follow ing the use of this drug. It would be expected that as with the sulfa drugs a patient sensitive to one antithyroid compound would be sensitive to any other in the series. However this is not always the case. The following report of thiouracil agranulocytosis with recovery and the substitution of propyl thiouracil illustrates this point.

Case Report

L. C, a 45-year-old woman was admitted to the Bronx Hospital April 25 1047 on the medical service because of sore throat and fover of two days duration. Four months prior to admission she developed asthenia and suffered weight loss of 88 pounds, nervousness and perspiration months after the onset of the above symptoms a diagnosis of hyperthyroidism was made. At that time she was placed on 0 4 Gm of thiouracil daily with a subsequent improvement. One week before admission she developed a pamful area on her gums four days later malaise fever chills, and, the day before entry to the hospital she complained of a sore throat. Temperature rose to a maximum of 105 2 Past history revealed that a heart murmur had been noted for the first time two months previously There was no history of rheumatic fever or known cardiao disease.

Physical examination revealed an acutely ill white, woman patient. Temperature was 103 F. pulse 114 The agnificant findings were a reddened pharynx with marked edema of the tonsillar pillar on the right, erosion of the inner aspect of the upper lip normal-axed thyroid and no thyrotoxic signs except for a fine tremor of the hands a blowing systolic nurmur at the apex of the heart, blood preserved.

sure 140/70 and normal lungs.

Prior to the return of the admission laboratory studies a diagnosis of acute pharyngitis, probably due to the thiouracil agranulocytosis, was made.

Laboratory studies are the following information Urine specific gravity 1 022, albumin, faint trace, acctone 1 plus, hemoglobin (Sahll) 90 per cent (13 9 Gm.) red blood cells 4 900 000 white blood cells 3 500 with 1 per cent neutrophils 2 per cent band forms 86 per cent lymphocytes and 11 per cent monocytes on differential smear Stemal marrow examination showed a maturation arrest of the granulocytes at the myelocytic level character sitie of arganulocytosis. Roentgenogram of the chest revealed a left vontricular enlargoment of the heart. There was no evidence of aberrant thyroid these or abnormality of the lungs. Roentgenogram the skull was normal. Gram-negative diplococci and

gram-negative bacilli resembling diphtheria organisms were seen on throat culture. Blood glucose was 89 mg, per cent and nonprotein nitrogen 83.5 per cent.

The history of theouracil therapy and the results of the blood count confirmed the diagnosis of agranulocytosis secondary to thiouracil. patient was placed on penicillin 50 000 units every three hours plus folic acid, 5 mg, four times a day Her temperature fell promptly and by the third day was normal. The normal temperature continued with an occasional rise to 100 F until discharge. With the fall in the temperature she began to improve, and on the second hospital day April 26 the white blood cells had risen to 5,300 with 72 per cent neutrophils, 62 per cent lymphocytes, and 1 per cent basophils on differential smear Tho white and differential cell counts remained within normal limits thereafter The pharynx appeared normal on the fourth hospital day April 28. The basal meta bolic rate on May 6 was plus 62 per cent. In view of the thyrotoxic condition, propyl thiouracil therapy was instituted on May 12 Penicillin, 15 000 units every three hours and folic acid, 5 mg. three times a day were continued The patient tolerated the propyl thiouracil well and there was no deleterious effect after penicilin was discontinued. On May 21 the metabolic rate was plus 29 per cent. On May 23 1947, she was discharged to the care of her private physician who three months later reported the patient was doing well, and her latest basal metabolic rate was plus 24 per cent.

Comment

It is known that an increase in the monocytes is a good prognostic sign for the recovery of the patient from the agranulocytic state. An increase of the monocytes was found on the initial blood smear The patient responded to therapy and the day following admission the granulocytes had risen to within normal limits. In view of the lessened tox icity to propyl thiouracil the patient was given this drug for her hyperthyroidism upon recovery from the agranulocytic state. While the drug was being administered daily blood counts were taken and penicillin was given prophylactically No untoward effects were noted after the discontinuation of penicillin Follow-up report three months later showed no evidence of toxicity

Conclusion

A case of thiournail agranulocytosis with recovery that responded to propyl thiournail without any deleterious effects has been presented. In similar cases daily blood counts should be taken to detect early evidence of toxicity Penicillin should be given prophylactically

628 East 141st Street

References

1 Morton J: Am. J Med 2: 53 (1947)

Thanks are due to Dr Max Welss and Dr Alfred B. Claments for permission to report this case and follow-up notes respectively:

Special Article

STATEMENT OF THE PRESENT POLICY OF THE AMERICAN TRUDEAU SOCIETY ON BCG VACCINATION

Prepared by the Chemotherapy Committee, American Trudeau Society, Medical Section, National Tuberculosis Association

THE members of the Society and other physicians In the United States have been interested for many years in the active immunization against tuberculosis with BCG. The expansion of public health activities in the field of tuberculosis control by official and voluntary agencies and the acquisition of new knowledge concerning immunity in tuberculosis have prompted the American Trudeau Society to make the following observations and recommendations

BCG vaccine, prepared under ideal conditions and administered to tuberculin negative persons by approved technic, can be considered harmless

The degree of protection reported following vaccination is by no means complete, nor is the duration of induced relative immunity permanent or pre-The need for further basic research on the dictable problem of artificial immunization against tuberculogis is recognized and is to be emphasized should be directed (a) toward the improvement of the immunizing agent, (b) to the development of criteria for vaccination and revaccination, and (c) to determine more accurately which groups in the general population should be vaccinated Several wellcontrolled studies are under way at the present time, and it is expected that others will begin within the near future

On the basis of studies reported in the European and American literature, an appreciable reduction in the incidence of clinical tuberculosis may be anticipated when certain groups of people, who are likely to develop tuberculosis because of unusual exposure, inferior resistance, or both, are vaccinated

In the light of present knowledge, vaccination of the following more vulnerable groups of individuals is recommended provided they do

not react to adequate tuberculin tests

1 Doctors, medical students, and nurses who are exposed to infectious tubercu-

All hospital and laboratory personnel whose work exposes them to contact with the bacillus of tuberculosis,

Individuals who are unavoidably exposed to infectious tuberculosis in the home,

Patients and employees of mental hospitals, prisons, and other custodial institutions in whom the incidence of tuberculosis is known to be high, and

Children and certain adults considered to have inferior resistance and who are living in communities in which the tuberculosis mortality rate is unusually high

В Vaccination of the general population is not recommended at this time except for carefully controlled investigative programs, which, as a rule, will be best carried out under the auspices of official agencies such as the US Public Health Service, State and municipal health departments, and other specially quablied groups

BCG vaccine should not be made available for general distribution in the United States at this time because (a) the most effective strain of BCG has not been agreed upon nor has fully satisfactory standardization of the vaccine been achieved, (b) the best qualified experts have not agreed as to the most effective method of vaccination, and (c) fully satisfactory arrangements have not been perfected for transportation and storage of the vaccine

The vaccine should be prepared only in accredited laboratories especially devoted to this task, in which virulent tubercle bacilli are not cultivated or handled and in which all other possible precautions are exercised to assure safety and quality of the product

Adequate record systems should be devised for management of the statistical problems involved in recording and following large numbers of vaccinated These and other problems of particular importance are now being studied on an extensive scale by official and voluntary agencies in the United States and in close collaboration with European

scientists experienced in this field
V The Society believes that, since BCG vaccination affords only incomplete, rather than absolute, protection, the most effective methods of controlling tuberculosis in the general population are (a) further improvement of living conditions and the general health, (b) reduction of tuberculous infection, which can be accomplished by modern public health methods and the unremitting search among presumably healthy individuals for patients with infectious tuberculosis, (c) prompt and adequate medical and surgical treatment of patients with active disease, (d) segregation and custodial care of those not amenable to accepted forms of therapy, and (e) adequate rehabilitation

Fortunately, great advances have been achieved during recent years in the development of diagnostic methods applicable on a mass scale, and there have been significant improvements in the surgical and medical treatment of tuberculosis. The expansion of modern diagnostic, therapeutic, and rehabilitation facilities is required at this time to make full use of these new methods which can accomplish further dramatic reduction of tuberculous mortality and

morbidity rates in the United States

It is to be emphasized that BCG vaccination must not be regarded as a substitute for approved hygienic measures or for public health practices designed to prevent or minimize tuberculous infection and dis-Vaccination should be regarded as only one ease of many procedures to be used in tuberculosis control Vaccination seems unwarranted in areas in which the tuberculosis mortality rate is extremely low and in localities in which the tuberculin test is of special value as a differential diagnostic procedure

This statement was prepared by the Chemotherapy Committee of the American Trudeau Society Drs J Burns Amberson Emil Bogen Paul A Bunn H Corwin Hinshaw Kirby S Howlett Jr Walsh McDermott Edward N Packard Carroll E Palmer William Steenken Jr Arthur M Walker C Eugene Woodruff, Guy P Youmans and H. McLeod Riggins chairman It was released for publication by Dr Howard W Bosworth president, American Trudeau Society Dr He

MEDICAL NEWS

Plans Announced for Brooklyn Long Island Medical Center

GIFTS totalling \$1,118,282 toward development of the proposed Brooklyn-Long Island Medical Center were announced recently by Dr Jean A. Curran president of the Long Island College of Medicine, to 300 graduates of the medical school assembled for the 68th annual Alumni Association Dr. A. W Martin Marno president praised the College s plans and pledged continuing support for the

Project.
Part of the funds have been used to purchase a new campus for the College the only medical school in Brooklyn and Long Island. On this site at Clarkson and New York Avenues the College plans to build research facilities to supplement the hospital resources contained in the municipal Kings County and Kingston Avenue Hospitals and the Brooklyn State Hospital When completed, the

development will create a center of medicine commensurate to the health needs of the 5 000 000 people living in this area.

Orr Marino who is also president of the Kings County, Medical Society predicted the development of a closer relationship between all community physicians after the establishment of the medical center

Special tribute was paid at the dinner to the 50-year class of 1898, represented by nine of its 23 living members. Oldest alumnus returning for the occasion was Dr Otto E. F. Risch. 87 who has practiced in Brooklyn for more than sixty years. Dr Risch recalled that he began his practice just four vears after the completion of the Brooklyn Bridge and eleven years before Brooklyn relinquished its independence to become a part of Greater New York City. Graduates were on hand from seven states.

National Conference on School Health Asked

A MAJOR attack on the school health problem is strongly advocated in a report prepared for publication by the maternal and child health section of the recent National Health Assembly held in Washington D C

This report, drafted by a steering committee headed by Dr Leona Baumgartner of the New York City Health Department, asks the Federal Security Administrator to call a National Conference on School Health with a particular view to getting

health and education departments to work together Recommendation is made that governors and

mayors call similar conferences

Dr Baumgartners committee also held that health departments had been ado-stepping their responsibilities for accident prevention and recommended

Since accidents are the chief cause of death of

children above the age of one it is recommended that accident prevention be considered a major responsibility of state and local health departments and that persons qualified in this field should be included on their staffs.

Real help to handicapped children the group decided after going through all reports available was not possible without knowing where they were and what were their ailments.

It was urgently recommended that a census of such children be taken with the census in 1950 and that the federal government continue to take such a census at regular intervals thereafter

A central clearing house in Washington, where all research experiments in progress for the physical and mental health of children would be regularly reported, was demanded as an absolute necessity for progress.

Cutter Laboratories Withdraw Solutions

FOLLOWING the discovery of contamination in Cutter 5 per cent saline solution and a glucose solution, Cutter Laboratories has requested that all hospitals return Cutter so neutre line of dextrose and other solutions for mass intravenous injection

The company is cooperating with the Food and Drug Administration and requesting the assistance of health departments throughout the country in immodiately recalling from hospitals all Cutter solutions for intravenous injection. Contamination was first discovered in Lot CM-8164 of Cutter 5 per cent saline solution, and later in another and on tirruly different glucose solution, doxtrose 10 per cent in Itinger s, according to an announcement made by Dr. R. K. Cutter profident of Cutter Laboratories.

Because company officials believed that discovery

of this new contamination makes questionable the use of any product produced in their intravenous solutions department until the entire contamination difficulty is solved, they asked for the recall of all Cutter intravenous solutions. The other producet produced in this department are concentrated dox tross, distilled water sodium citrate, normal saline solutions in 50- and 100-cc. bottles, as well as all flasks supplied by Cutter for blood and plasma banks

According to the Cutter Laboratories announcement "The reason for this contamination is still unknown and until they have a positive answer Cutter feels this is the only step that can be taken in the interest of public safety. In the meantime arrangements are being made to supply hospitals with solutions of other manufacturers.

UAW-CIO Health and Medical Care Advisory Committee

FORMATION of a UAW-CIO Health and Medical Care Advisory Committee is announced as a major forward move in the union's five-cente-forhealth drive

The new body of nationally recognized authorities on every phase of public and group health and medical care will regularly advise the Social Security Committee and Social Security Department in matters related to the union health and medical care program under the union's collective bargaining

demand for five cents per hour per worker for hospitalization, health, medical, and surgical serv-

New York physicians who have accepted appointment to the committee to assist UAW in program planning include Dr George Bachr, clinical director, Mt Sinai Hospital, New York City, Dr Dean Clark, medical director, Health Insurance Plan of Greater New York, and Dr Basil C MacLean, director, Strong Memorial Hospital

Tuberculosis Seal Sales Total Over Million

FOR the third year in succession, 62 county and city Tuberculosis and Public Health Associations in New York State, outside of New York City, have raised over \$1,000,000 in the annual sale of Christmas seals, according to final reports as of

April 1, 1948, the closing date of the 1947 sale The final total figure was \$1,226,901 47 and represents an increase of \$75,622 50 over 1946, a gain of 6 6 per cent The 1947 seals brought in \$76,901 47 over the goal set for the sale

Additional Schering Research Grants Announced

R ESEARCH grants to four additional leading medical institutions were announced by Schering Corporation of Bloomfield, New Jersey, manufacturer of endocrine products Included among

these is the Schering Fellowship for continued studies on the enzyme hyaluronidase, which has been renewed at the Cornell University, department of zoology, Ithaca.

MEETINGS

PAST

New York Council of Surgeons

Using demonstrations and lantern slides, Dr Wilbert Sachs, assistant professor at Cornell University and New York Medical Colleges, spoke on "Skin Lesions in Routine Practice" at a meeting sponsored by the New York Council of Surgeons, May 4, at Parkchester General Hospital, the Bronx

On May 18, Dr Abner I Weisman, associate attending gynecologist, Jewish Memorial Hospital, New York City, spoke on "Female Sterility and the

Gynograph."

Saranac Lake Medical Society

In a combined meeting with the Osler Society, members of the Saranac Lake Medical Society heard a talk by Dr Joseph Gordon, Ray Brook Hospital, on "Astrology in Medicine" May 5 at the Saranac Laboratory

National Council on Rehabilitation

"Making Rehabilition Work" was the subject of a discussion at the sixth annual meeting of the National Council on Rehabilitation, held May 6 and 7 at the Hotel Pennsylvania, New York City Speakers included Dr C D Selby, medical consultant of the General Motors Corporation, Dr Donald A. Covalt, medical director of the Institute of Rehabilitation and Physical Medicine, New York University-Bellevue Medical Center, and Dr Lazare Teper, research director of the International Ladies Garment Workers Union.

Society of Medical Jurisprudence

At the 634th regular meeting of the Society of

Medical Jurisprudence, held May 10 at the New York Academy of Medicine, the program included four talks, followed by discussion led by Dr Leonard J Goldwater, professor of industrial hygiene, School of Public Health, Columbia University

Speakers included Dr Irvin Kerlan, acting medical director, Food and Drug Administration, Federal Security Agency, "Combating Illegal Drugs and Devices", Dr Richard Kovacs, professor of physical therapy, New York Polychnic Medical School and Hospital, "Misuses and Dangers of Physical Therapy"

Also Mr Jerome Trichter, assistant commissioner, New York City Department of Health, "What New York City Is Doing About Drugs and Devices," and Mr George B Schoonmaker, former assistant US attorney, "Legal Safeguards"

Geneva Academy of Medicine

Postgraduate instruction, arranged by the Council Committee on Public Health and Education of the State Medical Society, in cooperation with the State Department of Health, was presented on May 13 for the Geneva Academy of Medicine

the Geneva Academy of Medicine
Speaker was Dr Wardner D Ayer, professor of clinical medicine, Syracuse University College of Medicine, on "Neurology in General Practice"

Association for the Advancement of Psychotherapy

Dr Alevander Wolf spoke on "The Psychoanalysis of Groups" at the meeting of the Association for the Advancement of Psychotherapy, held May 21 at the New York Academy of Medicine

FUTURE

American Otorhinologic Society for the Advancement of Plastic and Reconstructive Surgery

The next regular meeting of the American Otor hinologic Society for the Advancement of Plastic and Reconstructive Surgery will be held at the New York Academy of Medicino building, New York City on Thursday, June 10 at 8 r.m. Programs may be obtained by writing to the secretary Dr Norman N Smith, 201 Whitney Avenue New Haven 11, Connecticut.

American College of Chest Physicians

At the fourteenth annual meeting of the American College of Chest Physicians, to be held June 17 to 20 at the Congress Hotel Chicago, Illinois, several New York doctors will participate in the program Scheduled to present papers are Dr Irving Sarot New York City Enucleation Technic for Lung Containing Adhesions , Dr George Wright,

Saranac Lake, "Effect of Disease on Pulmonary Physiology", Dr George G Ornstein New York City, "Pulmonary Function, Dr Miltoe I Levine, New York City, "Experience with BCG Vaccination in New York City", Dr Herman E Hilleboe State Health Commissioner Albany "The BCG Program of New York State, Dr George N Papanicolaou and Dr Henry A Cromwell New York City, "Di amousts of Canoer of the Lung by the Cytologic agnosis of Cancer of the Lung by the Cytologic Method, and Dr Maurice M Black, Brooklyn "Biochemical Studies in Cancor Diagnosis."

American Venereal Disease Association

Plans for the tenth annual session of the American Venereal Disease Association have been announced. The meeting will be held June 20 and 21 in Chicago with the scientific programs to be presented at the Northwestern University Medical School.

PERSONALITIES

Retired

Dr Frank L. Babbott, for five years chairman of the board of trustees of the Long Island College of Medicine and former president of the College Dr Ames O Squire, Ossining Westchester County Medical Examiner for the past 23 years as of June 1

Honored

Eight Syracuse physicians professors in the Syracuse University College of Medicine at the annual faculty dinner April 24 including Dr Donald S. Childs, Dr. Fredenck S. Wetherell Dr. Brooks W. McCeen Dr. Wardner D. Ayer Dr. Carl J. Geiger, Dr. Herbert C. Yeekel, Dr. Louis M. Hickornell, and Dr. Neal J. Conan, all of whom will reture in June

Dr John Aikman, chief attending pediatrician at Genesee Hospital, awarded the 1948 Albert David Kauser medal of the Rochester Academy of Medicine

Dr Willis W Bradstreet, town health officer of Irondequoit, Monroe County for the past 30 years at a community celebration in appreciation of his long service. Dr Joseph Day Olin Watertown who retired from active practice January 1 after 40 years' service, at a dinner to celebrate his seventy fourth birthday and as a testimonial from his friends.

Appointed

Dr Robert Clinton Page, White Plains, as medical director of the Arabian American Oil Company to make his headquarters in Dhahran, Saudi Arabia, and supervise the company's six hospitals and numerous clinics.

Elected

Dr John Cannon, Scaredale, as president of the Westchester County Tuberculosis and Public Health Areociation, succeeding Dr Edwin G Ramsdell, White Plains Dr A R. Doches, New York City name Figure 2 of the Association of American Physicians, succeeding Dr A H Gordon of Mon-treal, Canada Dr Henry M Scheer, New York City as president of the New York University Col-lege of Medicine Alumni Association

Speakers

Dr Rene J Dubos, associate at the Rockofeller Institute for Medical Research on The Tubercle Bacillus and Tuberculosis' as the twelfth annual

Adam M Miller Memorial Lecture on May 4 at the Long Island College of Medicine Dr David L. Drabkin associate professor of physiological chemistry University of Ponns, Ivania, at the April meeting of the Long Island College of Medicine Research

ing of the Long Bland College of Modicine Research
Society on "Recent Advances in Cytochrome 'C'
Dr Russell B Erickson a staff member of the
Buffalo General Hospital, on "Hip Reconstruction
at a meeting of the Western New York Chapter,
American Physical Therapy Association.
Dr James P Fleming, Rochester on Preoper
ative and Postoperative Care of Cancer of the Rec-

tum and Colon" at the first world assembly of the International College of Surgeons which opened International College of Surgeons which opened May 15 in Rome, Italy Dr J G Fred Hiss, Syracuse, on the rheumatic fever problem at the Cortland Twentieth Century Club Cortland Dohn S. La Duc, New York City, on April 27, at the monthly meeting of the staff of St. Catherine a Hoscital Resolution of Chapter and Chapter pital, Brooklyn, on The Diagnosis and Treatment of Tumors of the Lymphoid System.

of Tumors of the Lymphoid System.
Dr Morris J Moskowitz junior surgeon at Highland Hospital Rochester, at the cancer control program arranged in Lima by Dalton Poet, American Legion Auxiliary, under the auspices of the Monroe County branch of the American Cancer Society Dr George T Paok New York City, on The Diagnosis and Treatment of Malignant Melanoma and The Extension of Radical Surgery in the Treatment of Cancer May 3 and 4, at the annual postgraduate seminar of the Medical College of Alabama, held in Birmingham, and on the second subject May

held in Birmingham, and on the second subject May 12 at the annual meeting of the Cancer Division, State Medical Society held in Oil City Pennsyl

vania.

Dr Samuel Sanes Buffalo chairman of the cancer control committee of the Eric County Medical Society, on the cancer problem April 21 at the Junior Chamber of Commerce public health night in Dr Isabel M Scharnagel April 16, before the Caducous Club New York University on The Radical Surgical Treatment of Cancer Ralph P Sikes, Yonkers health commissioner, on the organization of the mental health program in Yonkers, April 28 at a meeting of the Westchester Nur sery School Council.

[Continued on page 1295]

NECROLOGY

William M Bradshaw, M D, New York, died on May 1 at the age of sixty-four. He was graduated from the College of Physicians and Surgeons, Columbia University, in 1909 and interned at Bellevue Hospital. Dr Bradshaw was adjunct attending physician at that hospital until 1917, when he joined the Mutual Life Insurance Company, where he had served as medical director in charge for the past eight years. Dr Bradshaw was a member of the American Medical Association and the New York State and County Medical Societies and was a fellow of the New York Academy of Medicine

Edwin John Doty, M.D., of New York, died on March 19 He was forty-five years old Dr Doty was a graduate of the University of Michigan Medical School in 1929 He was a diplomate of the American Board of Psychiatry and Neurology and served as associate psychiatrist on the staff of the New York Hospital Dr Doty was a member of the American Psychiatric Association, the American Medical Association, and the New York State and

County Medical Societies

William Augustus Downes, M D, of Newburgh, died on May 10 at the age of seventy-five Dr Downes was graduated from the College of Physicians and Surgeons, Columbia University, in 1895, and served his internship at New York Hospital Dr Downes was professor of clinical surgery at the College of Physicians and Surgeons, Columbia University, from 1913 to 1932 and served as assistant chief surgeon for the New York Central Railroad from 1909 to 1931 He was a surgeon in the Army Medical Corps with the rank of major during the first World War

Formerly attending surgeon at St Luke's, Memorial, and Babies Hospitals, New York, Dr Downes had continued to serve as consulting surgeon to these institutions after his retirement fifteen years ago He was also consulting surgeon to the Hospital of Special Surgery, Ruptured and Crippled Hospital, the New York Infirmary for Women and Children, New York, the United Hospital, Port Chester, and the Stamford Hospital, Stamford, Connecticut A former member of the New York Academy of Medicine and the American Medical Association, Dr Downes was a fellow of the American College of Surgeons and a member of the American Surgical Association and the New York Surgical Society

Horace Gledhill, M D, forty-nine, died on May 2 at his home in Brooklyn Dr Gledhill interned at Methodist Hospital, Brooklyn, after his graduation from Jefferson Medical College, in 1923 He was an attending surgeon in laryngology and bronchoscopy at Methodist, Norwegian, and Victory Memorial Hospitals in Brooklyn and was a member of the Brooklyn Otolaryngology Society, the New York State, Kings County, and Bay Ridge Medical Societies, and the American Medical Association

Varney B Hamlin, M D, died at his home on April 12 at the age of seventy-eight Dr Hamlin was a graduate of the College of Physicians and Surgeons, Columbia University, in 1893, and had practiced medicine in Clinton since 1895 He was a member of the American Medical Association and the New York State and Oneida County Medical Societies

Cornelius Francis McCarthy, M D, of Auburn, died on May 5 He was eighty-one Dr Mc-

Carthy was a graduate of the University of Vermont School of Medicine in 1890 and practiced in Batavia until 1915. Since that time, he had practiced in Auburn. He was a consulting physician on the staff of Mercy Hospital, Auburn, and a member of the honorary staff of Auburn City Hospital. Dr. Mc-Carthy was also a member of the Syracuse Academy of Medicine, the American Medical Association, and the New York State and Cayuga County Medical Societies.

George Wilson Terry Mills, M. D., Brooklyn, died on May 8 at the age of sixty-eight. He was graduated from the University and Bellevue Hospital School of Medicine in 1902 and interned at Mount Sinai Hospital. A diplomate of the American Board of Psychiatry and Neurology, Dr. Mills was formerly superintendent of Brooklyn and Creedmore State Hospitals. He was a member of the American Psychiatric Association, the American Medical Association, and the New York State and Suffolk County Medical Societies.

Leon F Muldavin, M D, New York, aged thirty-seven, died on April 24 Dr Muldavin, a fellow of the American Medical Association and the British Royal College of Surgeons, was graduated from the University of London, St Mary's Hospital Medical School, in 1935 A former chief of the surgical service of Margate Hospital, London, he practiced surgery in the British West Indies until 1941 Dr Muldavin was assistant adjunct surgeon on the staff of Beth Israel Hospital and attending surgeon at

of Beth Israel Hospital and attending surgeon at Good Samaritan Hospital He was a member of the New York State and County Medical Societies Boris Rapoport, M D, of New York, died on May 4 He was sixty years old He was graduated from Tufts Medical School in 1914 and studied anesthesia

Tufts Medical School in 1914 and studied anesthesia in a postgraduate course at Harvard Medical School From 1918 to 1937 he was chief anesthetist at Beth Israel Hospital, Boston Since 1937, Dr Rapoport had been director of the department of anesthesia of the Hospital for Joint Diseases A diplomate of the American Board of Anesthesiology, he was a member of the American Society of Anesthesiologists, the American Medical Association, and the New York

State and County Medical Societies

Eugene Giles Ribby, MD, of Batavia, died on April 22 at the age of forty-eight Dr Ribby was a graduate of the University of Iowa Medical School in 1926 Formerly health officer for the towns of Byron and Stafford, he was chief of the department of urology of St Jerome's and Genesee Memorial Hospitals, Batavia Aformer president of the Genesee County Medical Society and of the staff of St Jerome's Hospital, Dr Ribby was a member of the Western New York and Ontario Urological Society, the American Association of Physicians and Surgeons, the American Medical Association, and the New York State and Genesee County Medical Societies

Charles C Roosa, M D, Buffalo, died on May 9 His age was ninety-one Dr Roosa was graduated from the University of Buffalo School of Medicine in 1899 Dr Roosa specialized in the treatment of

asthma and was retired

Arthur Jemmott Sayers, M D, of the Bronx, died on April 11 at the age of fifty-four Dr Sayers was graduated from Howard University Medical School in 1930 He served on the staff of Lincoln Hospital and was clinical assistant in surgers at Harlem Hospital Dr Sayers also served as physician for the International Workers Order

Robert Montfort Schley, M.D., aged seventy died on May 5 at his home in Buffalo Dr. Schley was graduated from Hahnemann Medical College of Phila delphia in 1902. He was a diplomate of the American Board of Psychiatry and Neurology and a new or of the Buffalo Academy of Medicino the American Medical Association, the American Psychiatric Association and the New York State and Eric County Medical Societies

William Schroeder, Jr., M D of Northport and Brooklyn, died on May 1 at the age of sixty-nine Dr. Schroeder was a graduate of the Long Island College Hospital in 1901 Ho was head of the Sanitary Commission of New York City from 1922 to 1933 During the was the served as medical director of a shell plant in Long Island A fellow of the American College of Surgeons, he was also consulting surgeon on the staffs of Cumberland Concy Island, Caledonia, and Prospect Heights Hospitals and was a member of the American Medical Association and the Now York State and Suffolk County Medical Societies

Cornelius James Seay, M.D., Scarsdale died on April 24. He was seventy four years old. Dr Seay a retired specialist in urology was graduated from the College of Medicine of Richmond in 1894 At one time chief of the urological clinic of the Homo of Relici New York he was a member of the American Urological Society the American Medical Association, and the New York State and Westchester

County Medical Societies

Grover A. Silliman, M.D., of Sayvillo, died on April 27 at the age of fifty-ewen. Dr Silliman was graduated from the University of Maryland Medical School in 1913 and served with the Army Medical Corps during World War I. Formerly coroner of Delaware County and supervisor of the Delaware County Tuberculous Sanatorium at Delhi he had served as coroner of Suffolk County for the last twenty years and had also been medical inspector of the public school systems of Sayville Oakdale Bohemla, and Holbrook. He was attending physician in the departments of obstetrics and pathology of the Southside Hospital Bay Shore and consulting sur geon on the staff of the Central Islip Hospital Can

tral Islip Dr Silliman was treasurer of the Suffolk County Medical Society secretary of the medical board of the Southside Hospital, and a member of the American Medical Association, the South Shore Clinical Society and the New York State Medical Society

Henricus Johannes Stander, M.D., of New York, died at his home in Scarsdale on May 2 at the age of fifty three Dr Stander was graduated from Yale University College of Medleine in 1921 interned at the New Haven Hospital, and then entered the department of obstetries at Johns Hopkins University During the latter period he took a two-year leave of absence to serve on the staff of the Royal Victoria Hospital London, for special training and also to study in Lunigrad, Russia

Director of all clinical and teaching activities in the fields of obstetrics and gynecology at the New York Hospital and Cornell Medical College since it opened in 1921 he helped formulate the plans and

policies for the medical center in 1929

Dr Stander received the medal of the Order of Finlay of Havana in 1937 and last year received an honorary degree of doctor of medicine from Dublin University He was a diplomate of the American Board of Obstetries and Gynecology and a follow of the American Callege of Surgeons He was also a member of the American Gynecological Society the American Association of Obstetricians Gynecologists, and Abdominal Surgeons, the New York Obstetrical Society the American Association for the Advancement of Science the New England Obstetrical and Gynecological Society, the American Medical Association and the New York State and Idings County Medical Societies

Alfred M Wise, M.D., Brooklyn, died on April 3
His age was sixty five He was graduated from the
University and Bellevue Hospital Medicat College in
1900 and joined the staff of Brooklyn Jewish Hospital where he had sorved continuously ever since
Dr Wise took a course of postgraduate study at
Harvard Medical School in 1928 and on his return
served first as attending physician and later as consulting pediatrist on the staff of the Brooklyn Jewish
Hospital A Hicentiate of the American Board of
Pediatrics Dr Wise was a member of the American
Academy of Pediatrics, the American Medical Association, and the Ney York State and Kings County

Medical Societies

MEDICAL NEWS

[Continued from page 1203]

New Offices

Dr William W Bennett, former flight zurgeen with the Army Air Forces, general practice in Millbrook Dr Harold E Klein formerly of Mar garetvile, general practice in McLean Dr Abraham Marvisch formerly of Lake Mahopac office for x ray diagnosis and x ray therapy in Peckskill Dr Oscar J Muller Army veteran, general practice in Little Falls Dr Hannibal

Paolozzi Army veteran formerly in Chicago general practice in Utica. Dr Werner Philipp Brooklyn, general practice in Great Neck

Dr Leo II trench Jr former captain in the Army Medical Corps, general practice in Olean Dr Anthony J Puglisi Tuckniboe now with Viac-Neal Momorial Hospital Berwyn Illinois to begin internship at Grasslands Hospitals, Valhalla, July 1

HOSPITAL NEWS

New York City Hospitals Need 3,000 More Nurses During Coming Year

BECAUSE of the increasing demands being made on nurses for expert handling of new drugs and therapies, New York City's municipal hospitals need an additional 3,000 nurses during the year 1948-1949, Miss Mary Ellen Manley, director, Division of Nursing, Department of Hospitals, said at the 75th Anniversary dinner of the Alumnae Association of the Bellevue Schools of Nursing held in May

"In spite of the recent introduction of the eight hour day and improved salaries, we are still under-staffed," Miss Manley said. "There are today 5,500 nurse positions in the Department of Hospitals' budget, but the demands being made on nurses for expert handling of modern drugs and 'shot' therapies are such that this number needs to be increased to 8,500" Miss Manley also praised the Bellevue Schools of Nursing for pioneering the train-

ing of nurses in the United States
"The philosophy set down when your school was founded in 1873, that nursing care be based upon the fundamental concept of regard for the sacred value of human life, the inviolability of human dignity, and the integrity of human relations, is today so deeply woven into the pattern of good nursing care that Bellevue's contribution in this respect is frequently overlooked if not entirely forgotten," Commissioner of Hospitals Edward M Bernecker told guests at the anniversary meeting at the Waldorf-Astoria.

"Bellevue has pioneered in providing a well-organized health program for its students, and its counseling and guidance work have won the sup-port of nurse educators everywhere," he continued. At the same time he announced the election of Mrs Nelson A Rockefeller as president of the Board

of Managers of the Bellevue Schools of Nursing Honor guests at the dinner were Mrs Elizabeth Wilcox Beckwith, of Centerbrook, Connecticut, class of 1883, Mrs Frances Dennis, New York City, class of 1889, Miss Margaret Woodworth, Albany, class of 1885, Mrs Mary McNeir Curtis, Oneonta, class of 1891, and Miss Esther A. McCarty, Syracuse, class of 1898 Miss McCarty is still active in her continuous nursing service since graduation and is superintendent of nurses at St Joseph's Hospital, Miss Woodworth, a veteran of World War I, has contributed 34 years to the nursing profession.

Clinical Conference on Child Problems Planned in Buffalo

DESIGNED primarily to help the general prac-Utitioner in the practical management of the child, in health and disease, a clinical conference will be maugurated in the fall by the staff of the Buffalo Children's Hospital, according to an announcement by Dr Mitchell I Rubin, head of the department of pediatrics at Children's Hospital Sessions will be held at the Hospital two or three times a month, and all members of the medical, profession in Erie County, particularly general practitioners, will be cordially invited to attend and to participate in the discussions

The Comitia Minora of the Eric County Medical Society, at its April 20 monthly meeting, heard an explanation of the program and then voted its enthusiastic endorsement of the project and pledged the hearty support of the Society

Previous to consideration of the plan by the

Comitia Minora, general practitioners in virtually all parts of Erie County were sounded out, and their reactions to the proposal were so favorable as to insure the success of the enterprise

"It is planned to take up in this Conference all phases of the care of children" Dr Rubin said 'The department of pediatrics of Children's Hospital believes there is a real opportunity here for service to the medical profession of Erie County, especially the general practitioners, and we will feel amply rewarded for our efforts if sessions of the Conference are marked by good attendance"

Dr Rubin said that he would be glad to receive

comments and suggestions from physicians as to the most suitable day in the week and hour in the day for the conduct of the clinical meetings. The volume of professional interest will determine how

often meetings will be held

City Health Department to Open Diagnostic Clinic by July 1

THE New York City Health Department intends to have the first of its proposed new diagnostic clinics ready by July 1 and will become thereby the first public health department to offer that service, Commissioner Harry S Mustard announced in May

The Health Department will use the \$2,416,650 increase in its budget for the 1948-1949 fiscal year beginning July 1 to establish ten diagnostic clinicstwo in each borough—as well as undertake some other new health services Hospital Commissioner Edward M. Bernecker said the additional \$5,183,350

allotted him would be spent as follows \$2,500,000 for rehabilitation services for patients disabled by disease, \$1,369,750 for care of patients in their own homes, \$2,014,600 for improvement of hospital clinics, and \$300,000 to extend hospital laboratory

Dr Mustard explained that even patients who beheved themselves well would be encouraged to apply to the diagnostic clinics for complete and regular check-ups, mental as well as physical

"If our thorough examination reveals anything

wrong,' the Commissioner continued, "we ll extend our inquiry in that direction Outside of offering some hygienic advice, however, we shall not treat anyone. Rather, we shall direct the patient to a physician a hospital, or a clinic for appropriate treatment. These examinations, which will go much further than the usual physical examination and will use the most modern technics and equipment, will be free

Dr Mustard said the facilities of the new clinic also would be available to needy patients referred by private physicians who knew their patients could not pay for special examinations required such as

electrocardiograph and x-ray

Dr Marcus D Kogel, general medical superinten-dent of the Hospitals Department, said it was planned to set up the first of the new outpatient departments in Queens General Hospital to follow with Bellovue Kings County, and Morrisanla, and eventually to remodel the clinics in each municipally operated general hospital.

The present laboratory services, particularly x-ray departments, are a "bottleneck" in city hospitals, Dr Kogel said Clinic patients have to wait as long as two months to get an x ray taken, while even in-patients wait a week. This is to be remedied simply by working the laboratories sixteen hours a day in stend of the present eight, and with two shifts.

New York City Expands Hospital and Health Care

MAYOR William O'Dwyer revealed in May, New York City's plans for "broad expansion of serv ices by the Hospital and Health Departments with \$7 000 000 in new mone, part of the revenue expected from the recently announced increase in municipal transit fares. The expanded hospital facilities were described by Hospital Commissioner Edward M Bernecker as a milestone in the ad vancement of medical care.

The Hospital Department, receiving \$4 000 000 in new funds, will spend \$1 368 750 to organize a de-partment of home care in each of the municipal general hospitals and in Goldwater Memorial Hos-

pital, Welfare Island.

The combined home-care departments will be able to take care of a total of 1500 patients, Dr Ber necker said. Bellevue Hospital, Kings County Hospital, and Goldwater Memorial will 'ultimately handle 200 home patients each Queens General Morrisania, Harlem Lincoln, Fordham City and Metropolitan Hospitals will take care of 100 cases each, and Coney Island Greenpoint, Cumberland and Gouveneur Hospitals will each handle fifty home patients.

"This is equal to adding 1 500 beds to the department,' Dr Bernecker said, or constructing build

ings costing at least \$22 000 000

Patients will be referred to the home-care departments, 'Dr Bernecker said, after it is determined that they no longer require the specialised facilities of a hospital but are still in need of active medical and nursing care.

The Hospital Department's social service branch

will decide whether a patient's home environment is suitable for home care Dr Bernecker said. The patient's hospital record will be continued as if he were still in a hospital ward, and patients will receive regular visits by hospital staff physicians. Nursing services will be arranged by contract with existing visiting nurse organizations, and "if this cannot be effected, the Hospital Department will set up a home

nursing section. Dr Bernecker also outlined a plan for strengthening the department s outpetient section, which he described as a "weak link" in the over-all municipal hospital soutp He said that outpatient sections to be established in four borough hospitals on a demon stration basis will be staffed and equipped so that patients can be 'completely and expeditiously worked up and appropriate treatment rendered with out recourse to hospitalization, or considerable diag nostic work can be completed prior to hospitalization

thus saving many hospital days.

The four demonstration clinics" will cost an estimated \$1014 600 annually, Dr Bernecker said However he added, "the elimination of waste and duplication of services of health and social agencies by preventing patients from starting on careers of invalidism, and the saving in hospital beds and the provision of excellent care will more than offset the

cost of this service

Dr Bernecker also reported plans to develop a dynamic rehabilitation service' for the bedridden and to operate x ray equipment for a full additional shift daily to "break the present bottleneck in

hospital beds

\$1,000,000 Free Medical Center Planned for Clothing Workers

ORGANIZATION of a medical center in New York City at which the 60 000 members of the Amalgamated Clothing Workers of America employed in the metropolitan area may get medical treatment without charge was announced in May by leaders of the union's New York Joint Board

It was also announced that the Amalgamated units in Philadelphia and Chicago are in the process of establishing similar medical centers for their members. The union is a Congress of Industrial

Organizations affiliate.

Initial cost of the New York Medical Center which is expected to be opened in three months will be \$1,000,000, with operating costs estimated at an additional \$500,000 a year. The funds are being contributed by the city's 400 men s clothing manu facturers who are members of the New York Clothing Manufacturing Exchange with no increase in prices anticipated as a result, it was reported. It was explained that there is an administrative surplus in an insurance fund set up for the workers by the employers under their contracts with the union, and that the companies have agreed to let the surplus be used for the center

Louis Hollander Amalgamated vice-president, said that the center would "be headed by a distinguished medical director soon to be announced, and by a staff of specialists well known in their respective There will be 'nominal charges only for fields. x-ray and other material costs, Mr Hollander said The Medical center was described by union and company representatives as another extension, on a local level, of the social-insurance system set up under the Amalgamated s national contracts.

75,758 Aided in 1947 by Work of New York Hospital

NEW York Hospital's staff and facilities restored or benefited the health of 75,758 persons in 1947, it was disclosed in the annual report issued in May The report also showed that during the year the hospital increased all of its major services above 1946 levels

A total of 76,340 patients were treated in 1947, as compared with 72,271 in the previous year. It was pointed out that those restored to health or "materially benefited" by the hospital's care represented 99 per cent of the 1947 patient load of the institution, whose facilities include the New York Hospital-Cornell Medical Center, its adjacent Payne Whitney Psychiatric Clinic, and the New York Hospital-Westchester Division, psychiatric hospital, White Plains

The hospital received \$447,823 from outside sources during the period to further an objective

second only to the care of the sick—research in cause and treatment of illness. Research projects included work with radio-active isotopes, studies in metabolism, the use of an oscillating bed in treatment of infantile paralysis, examination of the effectiveness and usefulness of such drugs as penicilin and streptomycin, and studies in neurology and psychomatic medicine.

The report showed an improvement in the nursing situation of the hospital, which gained 142 graduate nurses in 1947, as compared with fifty-four in 1946 and a loss in 1945. There also was a net gain of sixty-three in the supplementary nursing staff in

1947

The report also pointed up the hospital's progress in its third objective—teaching—which is being carried on in association with Cornell University Medical School

NEWS NOTES

An analysis of hospital service was presented at the May 17 clinical staff conference of the New York Infirmary, New York City—Reports of cases given were "Treatment of Nephrotic Stage of Chronic Glomerulo Nephritis in a Child," by Dr Frances Lande, with discussions by Drs Ruth Bakwin and Sophie Spitz, and "Hormonal Treatment of Metastic Carcinoma," by Dr Martha E Howe, with discussion by Dr Astra Wittner

Erection of a Quonset building as an addition to the Potsdam Hospital, an emergency measure to provide 21 more beds, has been announced by Paul P Sobering, hospital administrator The new structure will be used also to house the departments of radiology and deep therapy

The Clinical Society of the Lexington Hospital, New York City, met on May 17 Case presentations were by Drs S Wahl, G Weitzner, I Buch, H E Cohen, A Laszlo, A Paul, I Weitzner, and A Gottesman

The departments of ophthalmology of New York University and Bellevue Hospital, New York City, celebrated their Alumni Week, May 10 to May 15 Dr Conrad Berens delivered the address of welcome

At the April 8 meeting of the staff of the Northern Dutchess Health Service Center, Dr. Neil C. Stone, attending pediatrician at Vassar Brothers Hospital, Poughkeepsie, discussed some of the more common pediatric problems

Dr Edgar Medlar, associate professor of pathology at Columbia University and pathologist at Bellevue Hospital, discussed the pathology of pulmonary tuberculosis at the staff meeting at Castle Point Veterans Hospital, on April 28

A public forum on the "County Hospital Plan" was held in Sidney in April Dr John J Burke, chairman of the New York State Health and Hospital Planning Commission, was guest speaker The forum was sponsored by the Exchange Club

The Clinical Conference of Horace Harding Hospital, Queens, was held on May 10 Presentations were "Mortality Statistics," by Dr S Gilbert, "Cabot Case'Presentation," by Dr Feuerstein, with discussion by Drs E Sealand and J Shapiro, "Postpartum Hemorrhage," by Dr K Neimand, with discussion by Drs H Kava and F Clarke, and "Intestinal Obstruction in the Infant," by Dr Harris, with discussion by Dr H T Vogel

During the past year, Saratoga Hospital, Saratoga Springs, admitted 3,270 patients for 27,878 days, according to its recently released annual report In 1946 the patients admitted numbered 2,900 and the hospital days 24,078, or 3,800 less than those for 1947

The staff and board of trustees of the Vassar Brothers Hospital, Poughkeepsie, held a combined dinner meeting at the Nelson House on April 20 Constructive views relative to hospital policies were given, and the intern staff presented amusing skits

Cases were presented by Drs Emmett A Dooley, Walter D Ludlum, Henry H Ritter, and David Goldblatt at the meeting of the Clinical Society of Reconstruction Hospital, New York City, on May 19

Dr Abraham Ravich, attending urologist at [Continued on page 1300]

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[Continued from page 1298]

Adelphi Hospital, Brooklyn, spoke on "Urologic Diagnosis" at the May meeting of the Adelphi Hospital Staff Society Discussion was by Dr Moses Swick, associate attending urologist at Mount Sinai Hospital.

The first meeting of the new medical board of the Nassau-Suffolk General Hospital, Copague, was held on April 13 Guest speaker was Dr Samuel Alcott Thompson, New York City, who discussed the surgical treatment of angina by the establishment of pericardial adhesions Dr Milton J Raisback, professor of cardiology, New York Medical College, presented follow-ups of exhibition cases.

According to the annual report of Dr Frank C Sutton, medical director of Rochester General Hospital, the institution admitted 14,859 patients in 1947, giving them 128,741 days of hospital care Outpatients totaled 3,816 Born in the Rochester Hospital in 1947 were 2,628 babies

Dr Michael Heidelberger, professor of biochemistry at the College of Physicians and Surgeons, Columbia University, and chemist to the Presbyterian Hospital, New York City, delivered the sixth Bela Schick Lecture, which was given at Mt Sinai Hospital, New York City, on May 11 His subject was "Immunity in Children and Adults as Indicated by the Formation of Antibodies"

Dr Frank Gagan, of Poughkeepsie, gave an illustrated lecture on the value and necessity of bronchoscopy, at the April meeting of the Highland Hospital medical staff in Beacon

"Chinical Observations with Thephorin, a New Antihistamine Drug" was the subject presented by Dr James Gottesman at the Clinical Conference of Beth Israel Hospital, New York City, on May 11 Other speakers and their subjects were Dr William F Herzig, "A Case of Sclerodema with Small Intestinal Changes", Dr Aaron Silver, "A Case of Infectious Mononucleosis Simulating Trichnosis", Dr Selwyn Z Freed, "Vaginal Ureterolithotomy", Dr Harold Lusskin, "Ununited Fracture of the Neck of the Femur" Discussors were Drs. Louis Sternberg, Henry A. Rafsky, Frank A. Bassen, Seymour F Wilhelm, and Irvin Balensweig

The Hospital for Joint Diseases, New York City, sponsored the New York Rheumatism Association Clinical Conference on May 5 Speakers were Drs David Sashin, Henry Milch, Michael Burman, Ernest Stengel, A. Umansky, and H. Denber

On July 1, the New Rochelle Hospital will have completed its fifty-sixth year, during which time it has provided more than 2,500,000 days of hospital care. Each day there are on the average of 300 patients, and it requires approximately 400 paid employes and 100 or more volunteers to serve them. The New Rochelle Hospital is a nonprofit, nonsectarian community service.

What was formerly the X-Ray Hospital, New York City, has been reopened as a new Harlem inter-racial hospital under the management of a group of 94 physicians Dr Cecil Marquez, New York City, is chairman of the medical group

St Agnes Hospital, White Plains, is sponsoring chinico-v-ray conferences throughout the academic year. Open to the profession, the conferences have as their objective the discussion of interesting cases. They are held on alternate Thursdays, from 4 00 to 5 00 P M, and in June will take place on June 10 and 24.

During 1947 the Mercy Hospital, Buffalo, cared for an average of 40 more patients per day than it is equipped to serve, causing all the hospital's facilities to be overburdened. The \ray, laboratory, surgery, pharmacy, outpatient, maintenance, and administrative departments labored under space handicaps. New wings now being constructed will provide a minimum of 200 additional beds, with corresponding expansion of all specialty departments. The Sisters of Mercy, keeping in mind the importance of the family unit, have stressed the maternity and pediatric departments in the improvements.

Dr Henry L Simms, of the department of chemical pathology at the College of Physicians and Surgeons, Columbia University, and chairman of the study group of the National Institute of Public Health on Degenerative Diseases and Gerontology, spoke on "Nutritional Requirements for Adult Cells" at Doctors Hospital of Queens, Jamaica, on May 13 This was the second in a series of lectures of the Institute of Metabolism and Nutrition

The New York Post-Graduate Medical School and Hospital, New York City, in May unveiled a memorial plaque, dedicated to the 481 doctors, nurses, and other personnel from the hospital who served in World War II and to two doctors killed in service The plaque was unveiled by Mrs Lucina Ball Eckerson, widow of Dr Edwin B Eckerson, who was killed in 1945 aboard the hospital ship Comfort when a Japanese plane struck the sick bay Dr W Bruce Talbot, superintendent of the hospital, accepted the plaque on behalf of the staff

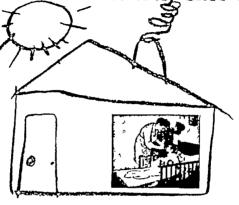
Staten Island Hospital, Tompkinsville, celebrates its fiftieth birthday in June, although its actual existence began more than thirty years before the corner stone was laid for the red-brick building on Castleton Avenue — In April, 1861, the idea was broached at a meeting of the Richmond County Medical Society that something be done to give Staten Island a home for its sick and injured — At that time the medical society was sponsoring a dispensary for the poor, which was extended to meet the increasing demands upon it

Opened in 1864, the new hospital was named the S R. Smith Infirmary in honor of a doctor who had "a reputation for activity in the line of benevolence which the proposed institute should follow" In

[Continued on page 1302]

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Eskadiazine

Smith Kline & French Laboratories, Philadelphia [Continued from page 1300]

1917 the Infirmary became the Staten Island Hospital, and on June 1, 1926, the new building, six stories high, was opened formally, with the bed capacity of the hospital increased to almost 300

In common with many hospitals throughout the country, Grasslands Hospitals, Valhalla, observed National Hospital Day on Wednesday, May 12, by holding an open house With the public of West-chester County invited to inspect the 815-bed hospital, the institution had displays and educational exhibits by which the visitors learned first-hand of the work and services performed there

In addition to the hospital's own exhibits, allied health agencies in Westchester County also sponsored exhibits. These included the Westchester County Health Department, the Red Cross, Westchester Tuberculosis and Public Health Association, the Westchester Chapter of the American Foundation for Infantile Paralysis, the Westchester County Cancer Committee, and the Grasslands Hospital Social Service Committee

Dr Albert Harris, associate bacteriologist of the Department of Health of the State of New York, was guest speaker at a meeting of the Little Falls, Ilion, and Herkimer Hospital Boards on April 22 He explained the county laboratory service to the board members in hopes that such a service can be established in Herkimer County

"Reformulations in the Theory of Neurosis" was discussed by Dr William V Silverberg, associate clinical professor of psychiatry at New York Medical College, at a meeting at the college on May 11

The Southside Hospital, Bay Shore, has organized a cancer detection center, to be supported by the Suffolk County Cancer Committee, which has been approved by the American Cancer Society and the American College of Surgeons—In the beginning, the center will be open to women over 35 years of age who are residents of the area served by the Southside Hospital—Persons wishing to register for the center must apply through their physician—The aim and purpose of the center is to follow a selected group of well patients for a period of years in an effort to detect in its early stages any malignant growth and to suggest the treatment to be followed

Buffalo's oldest hospital, the Sisters of Charity, is 100 years old in June, although its centennial celebration is planned tentatively for September 6, by which date the hospital will have moved to its new building on Main Street Its present building, in use since 1943 as the Louise de Marillac Hospital, will be given over to maternity and gynecology cases

The hospital's long history is studded with firsts." It was the first Buffalo hospital to admit interns (in 1855), the first to organize a training school for nurses, the first in which antiseptic surgery was practiced. It sponsored Buffalo's Emergency Hospital, the first such institution in the city, and opened the first maternity and children's hospital, St Mary's Maternity Hospital and Infant Home

The Clinical Society Conference of Beth David Hospital, New York City, featured case reports at its meeting on May 10 Dr Harry A. Solomon gave a report on "Lupus Erthmatosus Disseminata, with Prolonged Remissions," and Drs Louis Hauswirth and Harry Keil discussed the case Dr Jules D Gordon spoke on "Primary Closure of Decubitus Ulcers," with the discussion by Drs Frederic W Bancroft and Samuel Gaines "Erythema Palmare' was the subject of Dr Emil Zak, and was discussed by Dr Richard I Kulstein. Dr Morris F Goldberger reported a case of "Hystero-Salpingograms with Unusual Findings" and illustrated the report with lantern slides Drs Charles G Gottlieb and Mortimer N Hyams discussed the case

"Intramedullary Pinning in Fractures and Reconstruction Surgery" was discussed by Dr Frederick von Saal at the scientific session of the clinical conference at the Hospital for Special Surgery, New York City, on May 20

Hospital equipment, valued at more than \$1,000 when new, has been sent by the New Rochelle Hospital to the Municipal Hospital in La Rochelle, France, the New Rochelle-La Rochelle Committee announced recently. The equipment, which has become outdated and replaced by more modern American equipment, is expected to be of outstanding value to the French hospital. Among the items are an orthopedic table, until recently used in the operating room at the New Rochelle Hospital, surgical instruments and medical textbooks, some of them in French, operating room lamps, and furnishings for a nursery department

At the Conference of the Medical Chinics, City Hospital and Welfare Island Dispensary, held on May 21, Dr J Lowery Miller spoke on "The Present Status of Penicillin Therapy in Syphilis" Case presentations on the "Streptomycin Therapy in Tuberculosis" were given by Drs William Grady, H L Dowd, Henry Fleischman, Lillian Batlin, Frank Pierson, Lyman W Grossman, and Harry Gross

PERSONALITIES

Honored

Dr Charles Reid, South Jamaica, retiring as associate attending physician of Queens General Hospital, honored at a dinner given by his colleagues in April The first man to retire from the medical

service of the hospital because of age, Dr Reid had been associated with Queens General since 1935 and was the first president of the hospital's clinical society

[Continued on page 1304]

For Business Opportunities

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See

Pages 1309 and 1311

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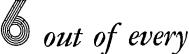
at the Einhorn Auditorium Lenox Hill Hospital on Saturday and Sunday June 12th and 13th 9-00AM.

The course has been arranged by the New York and Brooklyn Regional Fracture Committee of the American College of Surgeons

A fee of \$25 payable to the secretary should accompany applications. Veterans of World War II may take the course under the G I Bill of Rights They should send us forms 1950 and 303B together with a photostatic copy of their discharge papers. These forms are obtainable from the secretary

> William II Cassebaum, M D Secretary

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[Continued on page 1302]

Elected

As president of the hospital staff at St Agnes Hospital, White Plains, Dr Harry Klapper, assistant chief of the surgical staff Dr Frank Gagan, Poughkeepsie, as consultant for thoracic surgery and bronchoscopy at Highland Hospital, Beacon

Appointed

Dr Fred V Rockwell, formerly assistant attending psychiatrist, Payne Whitney Clinic of the New York Hospital, and assistant professor of psychiatry Cornell University Medical College, as chief psychiatrist at Grasslands Hospital, Valhalla as acting medical superintendent of Monticello Hospital, Dr Nathan Nemerson As attending physician at Ossining Hospital, Dr George W Hill, to the

associate staff of the hospital, Dr Leon E Kienholz and Dr Helen Crocker, to the courtesy staff, Dr R. H Hooker and Dr William Schacter Dr Herbert Chasis, New York City, as consultant in medicine at St Luke's Hospital, Newburgh, Dr Earl VanAmburg, Pine Bush, to the medical clinic staff, Dr Early C Morris to the surgical clinic staff, and Dr John McKeever as attending roentgenologist

Dr Louis R. Ferraro, formerly of Fordham Hospital, as attending pathologist and director of laboratories, St Francis Hospital, Poughkeepsie To the consulting staff of the Goshen Hospital, Dr Frederick T Seward, Goshen, psychiatry, Dr William J Hoffman, New York City, neoplastic diseases, and Dr Harry F Hirsch, Newburgh, derma-

tologists

CORRESPONDENCE

Prophylactic Instillation of Silver Nitrate

(The following 15 a copy of a letter sent to the New York Times See also editorial, New York State Journal of Medicine, p 858 April 15, 1948)

To the Editor

On page 18 of the New York Times for Friday, March 19, you print an advertisement of the Woman's Home Companion of an article which criticizes the state laws in their treatment of newborn children's eyes to prevent ophthalmia neonatorum. As you will see in the following regulation, in New York State a one per cent solution of nitrate of silver or some other agent equally efficient for preventing ophthalmia neonatorium, may be used Silver nitrate is not mandatory. This article in the Times gives the impression that penicillin should replace silver nitrate.

"Regulation 12 Precautions to be observed for the prevention of ophthalmia neonatorum * It shall be the duty of the attending physician, midwife, nurse, or other person in attendance on a confinement to drop into both eyes of the infant immediately on delivery a one per cent solution of nitrate of silver or some other agent equally efficient for preventing ophthalmia neonatorum"

"* See Penal Law, section 482, subdivision 3"

Dr Franklin M Foote, executive director of the National Society for the Prevention of Blindness, has written that the use of silver intrate versus

penicillin as a prophylaxis for ophthalmia neonatorum has been under consideration by a special committee of the New York Academy of Medicine for the past four months. To quote Dr. Foote "That committee reports that a one per cent solution of silver nitrate is entirely safe and satisfactory and should be continued in use until further research has been done with penicillin to prove that it is positively effective"

The New York Times is, to many people in this State, a guide not only for politics but a leader in advanced thought. We feel that it would be wise, in all fairness, to state in your paper the laws of New York State in regard to this preventive treatment. While we realize that you may have run this article as an advertisement, yet many people will feel that these statements have your backing. This article is not marked as an advertisement.

RAYMOND E MELK, M D, Chairman Medical and Advisory Committee New York State Department of Social Welfare, Commission for the Blind

March 24, 1948

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CORRESPONDENCE

The "Medical Center" Campaign

To the Editor

Were the representations which gained official endorsement of a Medical Center campaign (NY Med 3 22, (1947)) violated according to a plan which existed when the representations were made? The apparent violation was in the form of immediate full-page newspaper advertisements which revived the charlatanism of a previous generation in (1) open solicitation of patients, (2) cut rates ("The Center will make available to wage-earner groups a comprehensive system of lon-cost, year-round medical care" It "is planned to make the full benefits of modern science more broadly available, particularly to middle-income families and wage-carners"), (3) eulogy of professional skill (these doctors have "been responsible for the medical care given to three-quarters of the inpatients of Bellevue and for 250,000 outpatient visits a vear") Correlated with these advertisements were a series of news articles of obvious press-agent origin, lauding the miraculous cures and rehabilitation accomplished in this Center

In the language of the advertisements, "It's a big thing," and it poses a challenge for the proper committees of the Society and the New York Academy of Medicine to take correspondingly big action, or else grant similar license to individual practitioners or smaller groups who must compete in the treatment of "middle-income families and wage-earners" Conceding that the Medical Centers are too powerful to be subject to ethical discipline, are they subject to law? "Do not regard this as a charity Regard it as a legitimate business expense" persuasion is truthful, subscriptions to such a medical business are presumably not tax exempt the function of an educational institution to go into the business of supplying wholesale medical service to corporations? Has the legal status of "pay clinics" in hospitals been tested in court? Why is the law against corporate practice of medicine not enforced? Is not billing patients in the names of individual doctors and delivering the proceeds into an institutional treasury a transparent deception which can easily be exposed in court? Can charitable donations to a college or hospital be used to furnish magnificent buildings, equipment and laboratory and other services for a commercial medical system? Must physicians pay taxes to support a tax-free competition? Is not the ostensible comparison of different medical plans a farce, when free offices, intern, and other services are never given to independent groups but only to the huge monopolies to create false impressions of superior economy? I have waited vainly for somebody else to challenge the idealism or the necessity of the medical industrialization scheme revealed in the advertised prospectus, with doctors as white-collar employes under bosses appointed by the medical schools or by lay

A longer retrospect will show that physicians engrossed in their daily duties vainly have set up improvised defenses against a long-range oligarchic strategy, executed with deceptive propaganda and ruthless force strikingly similar to the methods used against democracy in Europe Starting from the

Rockefeller-Flexner stipulation of placing medical schools on a par with other university departments, and the proposal of the million-dollar Committee on the Costs of Medical Care for "medical centers" as a soviet form of democratic cooperation of all doctors in a community, the actual policy of these moneved interests has been the abnormal aggrandizement of the medical school into a monstrous Medical Center totally unlike any other university department, and a steady usurpation whereby a small oligarchy now dominates most of the medical and hospital system of a great city such as New York and stretches tentacles into the suburbs and upstate

There have been great benefits corresponding to the great sums of money, but they are separable from dictatorship Still greater benefits could be gained if other university departments were similarly transformed, for example, if the courts were taken out of politics and entrusted to the law schools, with eminent professors as judges, with minor positions furnishing invaluable practical training to students and young graduates, with counsel of certified ability assigned by the court instead of free choice of lawyers by the ignorant public, and with legal fees (now higher than medical fees and often as uneypected and necessitous) "socialized" so as to abolish the present unjust advantage of rich over Such benefits in this and other depoor litigants partments are rejected because a college is by nature a self-constituted self-perpetuating oligarchy, suited to its pedagogic purpose as an aristocracy of learning, but an extension of its power over public affairs is fascism. Furthermore the transfer of the struggle for power to within the college corrupts its academic Finally, no other social class, from lawyers down to the most ignorant laborers, could be induced to submit so supinely as the doctors

But the far-sighted early seizure of education has had several results of the type now familar in Europe First, while the great democratic mass of physicians display the normal wide variety of opinions on "socialized" medicine, the bringing of the key positions in medical schools under control by appointment and salary has endoned them with an impressive unanimity on this and related subjects. Second, there is thus assured a constant flow of indoctrinated medical students, who will steadily replace the dving independent generation in medical societies and elsewhere, so that this fifth column infiltration makes all democratic defense attempts futile and hopeless. Third, the self-styled "liberals" and "progressives" may notice another analogy with their European counterparts, namely, that they and an increasingly large proportion of New York physicians dare not venture any public utterance, such as the present letter, against the party line and policies established by a few overlords, and the loss of this American birthright of free speech outweighs any materialistic gains

Medical regimentation in this country is promoted not as part of a general socialization under dire necessity as in England, but by representatives of both capital and labor who insist on the freest initiative for themselves Without questioning the sin-

[Continued on page 1308]

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NEW CHEMICAL IMPROVES BLOOD TEST FOR SYPHILIS

Blood tests for syphilis are becoming more reliable thanks to a new testing chemical discovered by Dr Mary C Pangborn of the New York State Department of Health Details of the chemical and its use were reported by Dr Pangborn at the venercal discusse symposium held in Washington under the auspices of the National Institute of Health

When a blood test for syphilis is done on a patient with malaria or a vaccinated person the report often is positive even when the person does not have sy philis. Such tests are called false positives They have long been a source of worry to doctors and patients.

Many of these false positive tests will be eliminated when the new testing chemical is used it appears from results with it so far

The chemical is named cordiolipin. It is a phosphorus containing fatty substance obtained from beef heart. For many years extracts from beef heart have been used in blood tests for syphilis, but since these were crude extracts it was almost impossible to get two of them exactly alike. Consequently it was difficult to standardize the test material so that the test would be the same when performed in differ ent laboratories

Efforts to purify the beef heart extracts led to discovery of the new compound cardiolipin

Besides its advantages of specificity and case of standardization the new chemical has the further advantage of being adaptable to different test procedures.

-Science News Letter, April 17 1948

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[Continued from page 1306]

cere faith of the nonsocialist socializers in their cause and in their own fitness for leadership, it may be noticed that their self-interest is never left to mere faith, it is always assured in advance. Thus, the essential medical support of state medicine comes from groups which will clearly profit from it.

The spirit and methods in the monopolistic cap-

ture of one hospital after another do not necessarily conform to the pose of altruism, as I illustrated in a previous letter (N Y Med (Nov 20) 1945, p 30) Likewise, one effect of the recent unethical advertising is obvious, namely, exalted opportunity, power and reputation for a small group determined not by professional ability in comparison with their colleagues but by the money at their disposal In contradiction of the pretended cooperation with the free portion of the profession, these huge monopolies foster two evils (1) They make medical greatness dependent on money and inside organizational (2) While piously denouncing the dwindling evil of fee splitting, they substitute a bigger and better means of ulterior motivation, namely, the trading of patients within select groups, and the compulsion of subordinates to bring consultations to their chiefs How far the boasted munificence in support of research is sterilized by regimentation

could be shown if space permitted Mainly, there should be an awakening to one result of all the coordinated strategic schemes the spreading power of the Medical Center oligarchy will soon enable them to deliver the New York profession bound and gagged to whatever industrial or political system they choose Upstate will follow the City

Medical history illustrates the warning by Sccretary Hull (in the valedictory of his memoirs) of the, deterioration of public character amid scientific progress, the dangers of minority power, and the necessity of a hard struggle to rescue free initiative and the democratic heritage. A declaration of medical independence may hold these truths to be self-evident. The need of a medical school for a teaching hospital is not a valid pretext for domination of a small oligarchy over the medical system of a great city. Universal human experience has proved that every oligarchy, even if appearing beneficent at first, is or soon becomes oppressive, inefficient, and corrupt

, Frederick M Allen, M.D 1031 Fifth Avenue New York City 28

March 6, 1948

ASSAIL PLAN FOR DRAFTING OF DOCTORS

At its recent meeting in Chicago, the Council on National Emergency Medical Service of the A.M A adopted resolutions assailing the government's proposal to induct physicians by law into the armed services

The Council's objections, summarized in a statement prepared by the A M A Bureau of Legal Medicine and Legislation, have since been reaffirmed by the Executive Committee of the A M A Board of Trustees The complete statement, which has been forwarded to congressional committees considering proposed legislation to reactivate Selective Service, follows

"Prehminary prints of a Senate bill to provide for the common defense by increasing the strength of the Armed Forces of the United States, and to provide for a universal-training program, contain a section which would authorize the President, pursuant to requisitions submitted by the armed forces, to make special calls for members of the medical, dental, and veterinary professions, which have not yet reached the age of forty-five at the time of such call, in such classifications and in accordance with such priorities as he shall determine Persons so called will be liable for induction for service in the armed forces in accordance with such procedures as the President shall prescribe

"Such a provision is unnecessary, discriminatory, and constitutes a reflection on the patriotism of the medical, dental, and veterinary professions. Confining this statement of the proposed induction of physicians, it is strongly urged that during World War II, the medical profession met every demand for medical personnel without compulsion by law. It will do so again if the need arises. The provision is

therefore unnecessary and infers that in the case of urgency the medical profession will not respond to the needs of the armed services. It would seem to be predicated on a lack of faith in the patnotism of members of the profession. There is nothing in the history of American medicine to warrant such an inference.

"If a revival of the selective service program is made effective, there will arise a need for scientific and technical personnel, other than the three groups specifically mentioned, who are above the age limits to be applied to selectees generally Until provision is made for the induction of such other personnel, it is discriminatory to single out physicians, dentists, and veterinarians and subject them to compulsory induction

"The Association, through its Council on National Emergency Medical Service, has been actively engaged for many months in planning for the medical, health and sanitary needs of the nation in event of a national emergency

"At a meeting held in Chicago, Tuesday, April 6, the Council gave careful consideration to the present proposal to induct physicians by law into the armed services Resolutions were adopted embodying in substance the objections to the proposal summarized in this statement. These objections have since been reaffirmed by the Executive Committee of the Board of Trustees which has authorized this statement.

"It is urged, therefore, that the provision under which physicians may be inducted as such by compulsion of law be eliminated from proposed legislation to revive selective service"—Secretary's

Letter, A M A , April 19, 1948

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A reduction in the number of child accidents both fatal and nonfatal, is the objective of an intensive child anfety campaign to be launched this fall by the Metropolitan Life Insurance Company with the cooperation of the U.S. Children's Bureau, the American Academy of Pediatrics, and the National Bafety Council Accidents are the leading cause of Safety Council death among children of more than one year of age with death rates per 100 000 population far surpassing those of any other cause. For example in 1940 according to the experience of the Metropolitan among its industrial policyholders the accident death rate among children from one to four was 48.1 per 100 000, as compared with a rate of 28 2 per 100,000 for pneumonia the next leading cause of death. It is significant that at this age group there has been little improvement in the past fifteen years although the death rate from disease has been cut approximately 67 percent.

In the age group five to nine the death rate for accidents was 25 7 per 100 000 as compared with a rate of 4 6 for rheumatic fever and organic heart disease, the next cause In the age group 10 to 14, the death rate for accidents was 20 8 and that for rheu matic fover and organic heart disease 7.2

The present relatively low death rates from all nonaccident causes as compared with those of but a few years ago are the result of advances in medical

science and concentrated efforts in the field of child Efforts must now be intensified to bring health about a reduction in the number of child accidents The program is planned to encourage public health medical safety, and other organizations as well as the general public, to give even greater attention to the child safety phase of the child health program.

As part of the campaign the Metropolitan has prepared a 12 page illustrated booklet, Help Your Child to Safety While the booklet is addressed to parents and stresses the importance of cooperation on the part of all members of the family regarding child safety it also emphasizes some significant ways of combating physical hazards and unsafe practices resulting in child injuries The Metropolitan Field Force throughout the United States will cooperate in this campaign, as it has in so many others by distributing the booklet and in other appropriate ways will help to make the public aware of what can be done to cut down the tremendous toll of child accidents.

Supplies of the booklet and copies of statistical charts propared talks suggested press releases and other source material will be available upon request by September 1 for use in local organized child safety programs.

-Metropolitan Information Service

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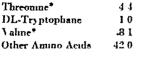


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A TIMELY MONOGRAPH

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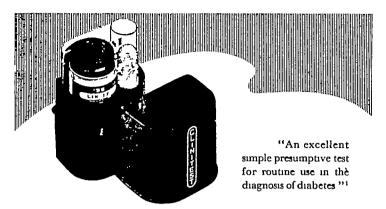
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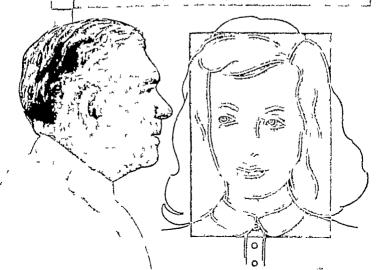
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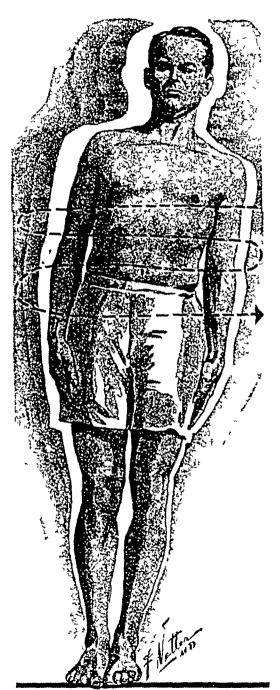
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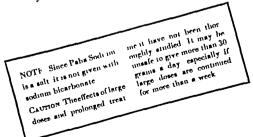
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*Charles J Marshall, New York Journal of Medicine, Vol 34, Aug 15, 1934

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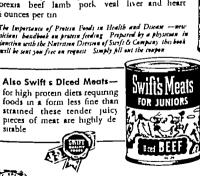
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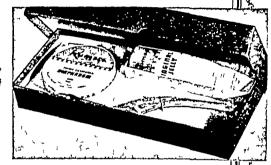
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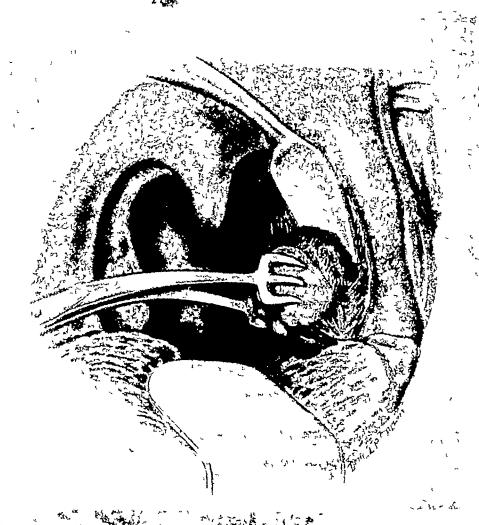
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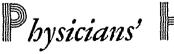


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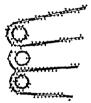
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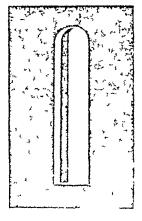
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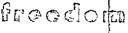
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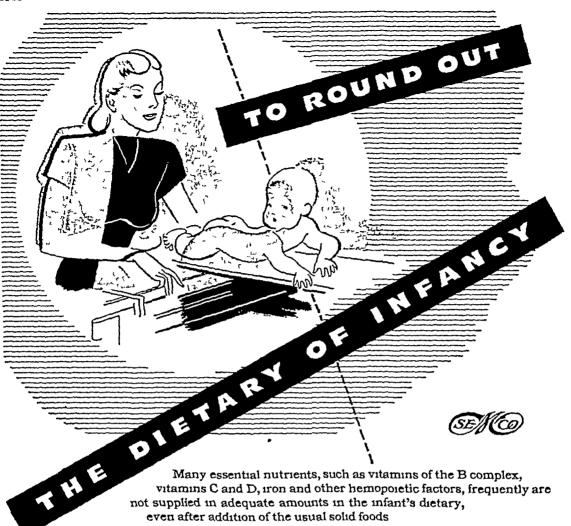


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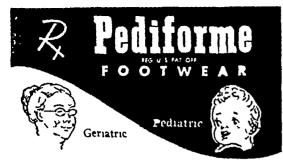
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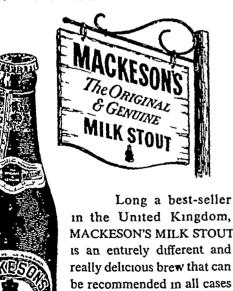


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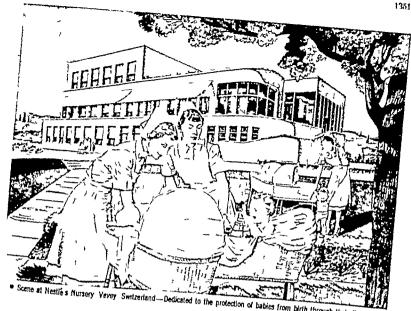
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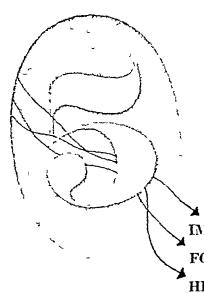


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Editorials

The National Health Assembly

As reported, the discussions of the delegates to the Assembly in Washington, May 1 to 4, called by F S.A. Chief Oscar R. Ewing, seemed to find certain "areas of agreement for a feasible ten year health program for the nation" 1

A review of the results of the discussions by the delegates at the fourteen major sections in which the Assembly was divided revealed that the areas of agreement were much greater than had formerly been believed, and this held out promise that the next ton years will see much progress in the distribution of medical care in rural health, in maternal health and child care, in medical research and education, in chronic diseases and rehabilitation of the disabled, and in a vast extension of voluntary prepayment group health plans embodying group Practice.

What was regarded by the delegates as the most constructive result to come out of the Assembly was the unanimous decision reached by the planning committee of the Medical Care Section which included two distinguished representatives of the American Medical Association (Dr. Thomas A. McGoldrick and Dr. James R. McVay) to accept in toto the first six of the eight objectives outlined in a statement by fifteen national organizations

with a membership of more than fifteen million, submitted before the Medical Care Section yesterday. The statement was submitted on behalf of their organizations by the delegates for the AFL and CIO, the National Farmers Union, cooperatives, physicians and veterans groups and social agencies.

The areas of disagreement remained, presumably, those on which differences have continued to exist, the methods of prepayment—voluntary or compulsory. It is hopeful and encouraging that representatives of the inedical profession, labor, industry, social agencies, and government continue to increase the size of the areas of agreement.

Many vital questions affecting national policy are at the moment of this writing coming up for decision. Shall Selective Service be re-enacted? Shall U M T be set up to secure the national safety? Shall a National Health Program emerge to implement the future health needs of a foresecable span of years in this nation, in which no definite assurance of peace can be had? These questions transcend petty considerations

1 New York Times, May 5, 1948, p. 6

It seems probable that in the future there will be no sharp demarcation between peace and war, that the national policy for security in which health must be included will have to be based on the probability of instant necessity for mobilization Such mobilization, particularly of medical and health agencies, obviously cannot be effective unless the areas of agreement shown to exist by the deliberations of the National Health Assembly are developed by all concerned to the fullest possible degree A well-integrated program cannot be pulled out of anybody's The grim menace of the atomic age should assist and encourage the immediate development of the areas of agreement outlined by the planning committee of the Medical Care Section of the Assembly only common sense and will be accomplished by rational debate and some concessions by all concerned

In the past, there has usually been time for extended experiment, protracted debate, and progress by trial and error—It would

not appear that unlimited opportunity may still be anticipated Events occur with startling rapidity in these days of the Atomic Age In February, 1948, 86 per cent of the doctors in Great Britain voted against participation in the Labor Government's universal "free" medical service scheme 2 As of May 5, 1948, a second plebiscite showed only 64 per cent of the doctors unfavorable, 25,000 voting against participation and 14,000 for it A majority of 13,000 of some 20,000 general practitioners was not obtained by the B M A to support its previous stand against participation 3 So rapidly can events move

With this in mind, development here of all possible areas of agreement between the medical profession and all other agencies concerned should be pushed as rapidly as is consistent with good judgment and sound planning

World Health

At this time, when large portions of the people of the world are sick, physically, mentally and spiritually, news of the secret tabling in the Congress of a bill which would have made the United States a member of the United Nations World Health Organization seems peculiarly discouraging haps the Rules Committee of the House of Representatives has felt that little progress could have been made, even with endorsement by the US, in view of disturbed world Certainly, the US share of the operating budget of WHO, 39 86 per cent, or about \$2,000,000 for the first year, could not have been a major consideration 1947, the Senate approved US membership in WHO, but the House Rules Committee tabled the measure indefinitely on March 12, giving no reasons 1

Already many interested groups, following the example of the New York Academy of Medicine, have protested the Congressional action in tabling the bill, and have asked for reconsideration of the measure. The fact that the US has not ratified membership in WHO is a matter of "embarrassment to the medical and public health professions of this country," in the words of Dr. George Baehr, president of the New York Academy of Medicine, and is "contrary to the advice of the American Public Health Association and all American experts in public health."

Doubtless the members of the Rules Committee of the House of Representatives were not unaware that the bill had been passed by the Senate and had the unanimous approval of the House Committee on Foreign Relations. It is our belief that the Rules Committee had its sufficient reasons, as yet undisclosed, for failing to consider the bill favorably. We cannot believe that the Committee, against professional advice, would have created a stumbling block to the putative advancement of world health and

New York State J Mrd 48 857 (Apr 15) 1948
 New York Times May 6 1948 p 15

¹ New York Times (Mar 22) 1948.

the international control of disease without compelling reasons, possibly by their character undisclosable at the time of the Committee's unfavorable action We hope that reconsideration will shortly be accorded the bill, and that the United States may take its place as a member of the WHO in due course

Current Editorial Comment

Increasing Hospitalization Important in Medical Care The hospital apparently is becoming more and more the place where medical care is being obtained by increasing numbers of the people of this country 1946, "More than 15,000,000 patients were admitted to hospitals in the United States, about double the number in 1935' 1 This astonishing growth is attributed to a variety 10 per cent increase in the popuof factors lation in a decade, 37 per cent increase in the bed capacity in the same time, centering of medical practice in the hospital in a greater number of communities, improvement in economic conditions since the middle 1930 s, group hospitalization plans The Bulletin states that about "one third of the total population of the United States is now covered by such plans "

Births and deaths in hospitals have been increasing, indices of the growing importance of the hospital in medical practice, births increased from three out of every eight babies in 1935, to three out of four in 1945, while in the latter year "slightly more than 46 out of every 100 deaths in the United States occurred in hospitals or related institu

Twenty years ago, the same source says, there were seven hospital beds per 1,000 of population, just before World War II, 10 per 1,000 By the end of the war there were 13 plus per 1,000 due to temporary facilities erected by the Army, Navy, and Merchant Marine, but these decreased with demobilization to 10 5 in 1946, this figure approximates present hospital facilities

As might be anticipated, wide differences exist in the availability of hospital facilities in the various states, but this will be somewhat equalized by construction authorized in 1946 by the Hill Burton bill

More hospitals and health centers, especially in the southern and rural areas of the country will provide the American people with the groundwork for excellent medical care. To this end it will be necessary also to train a

larger number of doctors, nurses and technicians 1

It is thus seen that the problem of integrating hospital construction and training of physicians, nurses, and technicians becomes one of major importance and also of considerable complexity. Such growth as is here indicated in the utilization of hospitals may be expected to continue, provided no major catastrophe in the national economy occurs.

Eight years ago, for instance, there were 4,201 000 hving veterans in the US² and the VA budget was \$050,000,000, by December 31, 1946, says the same source, there were 18,101,000 who made "in that year alone 40,000,000 calls for aid from the VA"

One seventh of our population seems now to be eligible for "life long free hospital care through the Veterans' Administration" Says the Digest, the "records show that last July 39,310 veterans with normal civillan illnesses were admitted to veterans' hospitals, as against 8 915 with war disabilities" Ninety-one hospitals are now being built to supplement the 124 hospitals already constructed with a total of 108,000 beds, for the care of veterans

This conveys the general picture of the growing importance of hospital facilities in the mechanism of the production of medical care. It indicates the enormity of the problem of training personnel, doctors, nurses, technicians and the extent of the ancillary or nonprofessional services which are involved. The problem is one which will need all the skill and foresight of the wisest among us to solve in the best interests of the sick and disabled.

* Reader's Digest (Feb.) 1948, p. 5.

Cancer Among Diabetics Statistics are defined as "(1) Systematized numerical facts collectively, and (2) the science that deals with the collection and tabulation of such facts." It has been said that any proposition may be supported with sta-

¹ Statistical Bulletin, Met. Lif Inc. Co. (Dec.) 1947 p. 7

A pessimist has classified the source of all untruths as hars, damn hars, and statistics The validity of statistics rests on comparable values They are truthful and valuable in proportion to the elimination of variables, the application of controls, and the use of corrections for data not otherwise reconcilable The elucidation of the facts concerning morbidity and mortality statistics containing complex variables often presents problems for experts—the statisti-The incidence of cancer among diabetics by Paul H Jacobson is a valuable scientific contribution for two reasons (1) it appears to indicate a higher incidence of cancer among diabetics than among nondiabetics, and (2) it contains pointed lessons for physicians on the hidden dangers of undigested statistics 1

An example of a hidden shoal on the smooth sea of statistics is the following In one table he shows cancer is reported as a cause of death for 116 per cent of nondiabetics, but for only 40 per cent of Those figures are completely diabetics misleading, however, because they are based exclusively on the universe of the Mortality ratios may be based on the universe of the dead (11 17 per cent of all deaths in the United States in 1940 were attributed to cancer), or on the universe of the living (cancer was reported to have caused the death of 0 12 per cent of the total population of the United States in 1940)

Mortality data are relatively easy to obtain and are frequently misused or mis-interpreted. If "we wish to reason in regard to the functioning state of an individual, we must study a population of Since we intend to deterliving persons mine relationships in order to ascertain whether one condition is predisposing or antagonistic to another, we should use a universe of living persons" Wilson found, for mortality from cancer and diabetes, dissociation in the universe of the dead. and association in the total population Applying Jacobson's method to the United States population in 1940, and to the population of New York City in 1930, he found the deaths from both causes 29 to 35 times more frequent than expected deaths calculated specific for age, sex, and color, cancer and diabetes were reported jointly 6.4 times more frequent than might

¹ Jacobson Paul H Milbank Memorial Fund Quarterly 26, 90 (January) 1948 be expected in the United States in and 64 also for New York City in 19

He modestly concludes the 28 pag statistical elucidation with the state that "No conclusion is tenable from evidence presented to explain the prevalence of cancer among diabetics findings, however, appear to indicate the incidence of cancer is higher a diabetics than nondiabetic individu Those who consult the original articl find that it requires more than just rea it demands study and close applica Those with a taste for statistics will it, and others should read it to whet skepticism and critical attitude, pa larly toward the deluge of deceptive mercial statistics

When to Die — Ecclesiastes states "to every thing there is a season, and a to every purpose under the heaven. A to be born, and a time to die Evidently, with respect to the last not the writer of the following had other when he penned anonymously

I wud knott dye in Wintur, when w punchiz flo-

when pooty gals are skating ore fealds of sno when sassidge meat is phyrin, & Hickeri i

thick,

Owe! who cud think ov dighin or even

sick?

I wud knott dye in Springtime, & miss th up greans,

& the pooty song ov the leetle frawgs, & skilark's early screems

When burds begin their wobblin, & tate tew sprout—

when the turkies go a gobblin, I would then peg out!

I wud knott dye in Summer, & leave the g

the roasted lam & butter milk—the kool in the grass.

I wud knott dye in Summer, when everyt so hot,

& leave the whish Jewlips—Owe know rather knott

I wud knott dye in Artum, with peaches eatin.

when wavy korn is getting ripe, & kandi are treetin.

for these, and other reasons, Ide knotte of the Phall.

& sense I've thort it over—I wild knott of all

¹ Chap 3, 1



JOHN J MASTERSON, MD

President Elect Medical Society of the State of New York

Dr John J Masterson, chosen President-Elect of the Medical Society of the State of New York at the annual meeting, May 17 to 21, 1948, in New York City is a native of Brooklyn, and his long and active medical career has centered about that community

Receiving his early training at the Long Island College Hospital, from which he was graduated in 1908, he became attending roentgenologist at the

Coney Island, Harbor, and Victory Hospitals, in Brooklyn At present he holds a similar position at the Norwegian Hospital, Brooklyn

Long connected with many organizations in the medical field, Dr Masterson has served as president of the Medical Society of the County of Kings and the Academy of Medicine of Brooklyn, the New York Roentgen Ray Society, the Brooklyn Roentgen Ray Society, the Associated Radiologists of New York, the Alumni Association of the Long Island Medical College, the Bay Ridge Medical Society, the Médical Board of Norwegian Hospital, and the Federation of Catholic Physicians Guilds

Since 1926 he has been a trustee of the Medical Society of the County of Kings, and chairman of the Board of Trustees since 1937 He is also a trustee of the Medical Society of the State of New York and of the Long Island College of Medicine

A director of the Brooklyn Tuberculosis and Health Association and the Catholic Medical Mission Board, Dr. Masterson was named a director of the Associated Hospital Service of New York in 1940, and of United Medical Service, Inc., in 1944. During the New York World's Fair, he served as a member of the Medical Advisory Committee.

Dr Masterson has served as a member of the House of Delegates of the Medical Society of the State of New York since 1923, and of the House of Delegates of the American Medical Association since 1935

In addition to membership in these organizations, he is a fellow of the American College of Radiology, a diplomate of the American Board of Radiology, and a member of the Radiological Society of North America, the New York Academy of Medicine, the Pan American Medical Association, the Associated Physicians of Long Island, and the Celtic Medical Society

Scientific Articles

THE DIAGNOSIS OF PRIMARY CARCINOMA OF THE LUNG

DEGRAAF WOODMAN M D New York City

(From the College of Physicians and Surgeons Columbia University)

THIS study dealing with the diagnosis of primary carcinoma of the lung will emphasize the importance of the teamwork needed between the elimenn, roentgenologist bronchoscopist, and thoracis surgeon. It will note the relative frequency of success of the various methods of making that diagnosis and lay special stress on the factors which may help us improve our efficiency in the early diagnosis of this disease.

The 116 cases analyzed were taken from the case histones of the Presbyterian Hospital over a twenty year period starting in 1926 and including all cases up through the first half of 1946. The cases represented here are all those that could be gathered from the records with a diagnosis of primary carcinoma of the lung proved by tissue examination.

Adminiation

TABLE 1 -NUMBER OF CARES BY FI E YEAR PERIODS

	Number of Cases
Years	or Carre
1926 to 1930	,3
1931 to 1935	15 29
1935 to 1940	54
1941 to 1945 1946 (first slx months)	S.
1840 (mint six months)	
Total	116

According to Table 1 primary careinoma of the lung is apparently on the increase. This may in part be due to better clinical diagnosis. Arkin states that the clinical diagnosis percentages had increased from 5 per cent in 1916 to 50 per cent in 1936 ¹ Today, the clinical diagnostic average is 80 per cent or better. Adams reported a series with close to 80 per cent clinical diagnostic success this year ²

TABLE 2 -- AVERAGE AGE OF PATIENTS

Age of	Number
Patients	of Cares
30 to 29 years	5
40 to 49 years	30
50 to 59 years	40
60 to 69 years	36
70 plus	4
Total	116

The average age for the 116 cases was fifty five years Ten of the cases were women (9.5 per cent) soven of the cases were Negro (6 per cent) The average age and age decade of greatest frequency agrees with reports of Holinger, Hammond Simons, Singer, and Oschner *-* The ratio of 9.5 per cent women to 90.5 per cent men is relatively low as compared to reports of Hammond Simons, Singer, and Oschner, but is more nearly in accordance with Holinger and Stephens. *-** The ratio of 6 per cent Negro to 94 per cent white patients closely approximates a report by Quinland at the University of Chicago *

Symptoms

Inasmuch as early recognition of the disease offers the only solution to successful surgical control this responsibility generally falls on the clinican

The chief early symptoms are productive cough with sputum (which may or may not be blood tinged) pain, weight loss, weakness and dyspnea. The first symptoms associated with the disease may be vague, such as a persistent cough. The cough, at first nonproductive may become mu coid later, followed by purulency and still later by blood tinged sputum. Such a sequence may often be passed off as a cold, bronchitis eigerette cough, or atypical pneumonia, and, not infroquently, it is thought to be a tubercular lesion, and the patient is sent away for sanatorium care

Pain may start as a slight feeling of constriction in one part of the cheet and later produce the feeling of limitation of full expansion of this part of the cheet. Still later the disconfort becomes more aggravated by cough and may carry on thus for some time before becoming a prominent, and not infrequently the chief, symptom

Blood-tanged sputum and frank hemoptysis are not inclined to develop until ulceration takes place and the disease is well established. Dyspnea and weakness generally come as the constriction and stenesing action of the growth causes at electasis and cutting out of lung areas from further ability to earry on oxygen exchange. Weight loss may continue progressively without much evident pulmonary symptomatology. Development of nodular swellings, hoarseness, referred pains, and even intracranial symptoms with accompanying palsies may be the first symptoms of the patient's loss of well-being

TABLE 3 —FREQUENCY OF CRIEF FIRST STAFTOMS IN THIS SERIES

	Number of Cases
67—P	roductive cough in 60 cases 10 of which showed bloody
	sputum
25	•
5	r
4	
ã	
ă	
	25 5 4 3

Later, during the course of the disease, the symptoms become more numerous Table 4 lists the various symptoms and the number of times they were recorded in 112 of the cases in this series

TABLE 4 -Incidence of Symptoms in 112 Casts

	Number of
Symptom	Cases
Cough	
Productive	89
Nonproductive	7
Pain	73
Pain in chest	54
Referred pain	19
Weight loss	53
Blood in sputum	45
Dyapnea	28
Hemoptysis	20
Weakness	18
Temperature elevation	13
Night sweats	6
Hoarseness	5
Wheeze	4
Nausea	4
Dysphagia	65443333
Horner a syndrome	3
Paralysis	3

Physical Signs

The first physical signs are generally those associated with partial and finally complete obstruction of a large bronchus Early in the disease no signs are manifest until obstructive signs with infiltration of tissues surrounding the bronchi occur Later signs of secondary infection and ulceration may appear

Emphysema, accompanying partial obstruction or compensatory emphysema, contralateral or in another lobe, following complete obstruction, may be present Bronchiectasis with infection and patches of pneumonitis may develop Later, as complete obstruction occurs, at electasis develops with pleural thickening and occasionally with pleural fluid present Accompanying at electasis and deflections of the trachea and mediastinal structures may be noted toward the side of the lesion Limited expansion of the affected side with dullness and flatness, together with absent or diminished breath sounds, are the usual findings

Cyanosis with engorgement of veins of chest wall, lymph glandinvolvement of the supraclavicular and axillary nodes, and even superficially evident metastasis growing to chest wall may be present. Distant metastasis, such as may result in brain lesions, causing hemiplegias, should be

considered and are at times the first indication of the disease

The superior sulcus type is characterized by pain high in chest, frequently referred to the arm and shoulder, occasionally accompanied by Horner's syndrome resulting from pressure against the sympathetic ganglia. At times the apical lesions may cause hoarseness resulting from pressure against and paralysis of the recurrent nerve

Interval Between First Symptoms and Final Diagnosis

The time between the first symptoms and entering a hospital for diagnostic study averaged forty-Inasmuch as successful surgical confive weeks trol depends on getting at the disease before it has spread, the ability to cut down on this period offers one of our greatest hopes for improving end results of this branch of surgery Greater publicity of the need for a thorough check on any cough of over three weeks' duration and the stimulation of more routine and group 1-ray surveys of the chest might also catch a few of the unsuspected cases The average time between first symptoms and first seeking medical advice was twenty-six and a half weeks This is the period of chronic cough with or without productive sputum, with perhaps a vague pain, sense of constriction, or limitation of full function of one side of the chest This group of symptoms is not enough to cause the patient sufficient concern to seek medical aid, but this is the period during which greater publicity might help to bring in many more cases before it is too late

The period between first seeking medical advice and finally being admitted to a hospital for diagnostic study averaged seventeen and a half weeks. During this period, many did not get started toward the hospital for diagnosis until the taking of an x-ray showed an unexplained shadow or the sputum became blood-tinged and caused alarm.

Once in the hospital the average time in which the diagnosis was made and proved by tissue study was as follows of 111 cases, six cases, all of which occurred on the average of fourteen years ago, took over one hundred days, 105 cases averaged ten days. Of this latter group 34 cases were diagnosed within forty-eight hours, and 31 of these were diagnosed by bronchoscopic biopsy

X-Ray Examination

The roentgenologist is generally the one who has the first opportunity to point his finger in the direction of the final diagnosis. He has a high percentage of diagnostic success and also shows the need of carrying out further diagnostic procedures such as bronchoscopy or exploratory surgery

Golden briefly summarized the roentgenologic

findings associated with primary carcinoma of a main bronchus 16 He stated that roentgen find ings first present streaky shadows radiating from the hilum and later present the effects of bronchostenosis, with bronchiectasis, atelectasis and plearisy with or without fluid formation findings, together with signs of shift of the mediastinal structures and traches, are the findings which suggest the diagnosis of carcinoma of the bronchus and the need for bronchoscopic study He also states that peripheral tumors have well demarcated margins. Their structure is frequently rounded, and their size may become con siderable without any evidence of obstructive emphysema or bronchostenosis. These factors are most likely explained on the basis of the greater opportunity of collateral respiration which occurs toward the peripher, whereas those lung tumors more centrally placed are inclined to develop stenosing effects on the larger bronchi with accompanying atelectasis and compensatory emphysema

Rabin divided neoplastic lung cases into two main groups, termed circumscribed and the non circumscribed types.11 The circumscribed type comprises one-fourth of the cases Cancers of the circumscribed type occupy the parenchymal and peripheral sones and are termed parenchymal and peripheral tumors Regional lymph node involvement occurs late and is limited peripheral tumors grow from branch bronchi and therefore, may be termed branch bronchus cir cumscribed tumors The noncircumscribed type to which three-fourths of pulmonary cancers of the lung belong, comprises tumors growing from These neomain and from branch bronchi plasms are termed main bronchus and branch bronchus tumors They present the usual in vasive characteristics of cancer in the great majority of cases

In this scries the x-ray reports were divided into three groups—with the following classification of each group—Group—I consisted of reports in which a definite diagnosis was made, stating that the lesion was, or most probably was, a bronchogenic carcinoma—Group—II reports stated that the findings were probably the result of a bronchogenic carcinoma or that bronchoscopy was indicated for aid in making the diagnosis—In group—III—the x-ray report gave no suggestion of the

TABLE 5 -CLARAIFICATION OF 104 CABLE ACCORDING TO

Group I II III	Number of Cases 40 43 15	Percentages 44 2 41 4 14 4
Total	104	

correct diagnosis or findings which indicated the need of bronchoscopic study

In this somes the x-ray reports were available in 104 cases. They were classified as shown in Table 5. Groups I and II represent 85 6 percent of the cases in which x-ray was of definite diagnostic value.

Bronchoscopy

It cannot be denied that bronchoscopy still offers the most definite means of making a positive diagnosis through biopsy and actual tissue examination. In this series 107, or 92.3 per cent of the cases were bronchoscoped, and 73, or 70 per cent of these cases yielded positive bronchoscopic biopsies.

The 107 cases which were bronchoscoped resulted in 34 cases with negative biopsies. The majority of these 34 cases showed presumptive findings suggestive of lung neoplasm. Findings such as deviations of the trachea vocal cord paralysis, broadening of the carina, fixation, and lack of mobility of the bronchila tree, longitudinal rugal folds of the lining mucosa of the bronchilal are findings frequently associated with lung neoplasm either extrabronchial or at times far out in the periphery where it cannot be seen with the bronchoscope.

Of the nine cases in this series which were not bronchoscoped, the diagnosis was made by the following nine procedures—thoraceutesis spon taneous coughed up specimen biopsy of supra clavicular nodes exploratory thoracotomy, pneu moneetomy, blopsy right mammary region partial lobectomy, lobectomy and partial exclaion of chest wall and lobectomy

Of the 34 cases bronchoscoped with negative hopsy results, the diagnosis was made according to the procedures shown in Table 6

TABLE 6.--PROCEDURES USED IN DIAGROMS

Procedure	Number o
Pneumonectomy	10
Exploratory thoracotomy	9 (
Lobectomy	7
Thoracentesis	2
Trephine for brain metastasis	3
Coughed up specimen Biopsy of abdominal wall	3
Biopsy of abdominal wall	1
Laminectomy	3
m	34
Total	34

In the above group of 34 cases presumptive bronchoscopic findings suggesting lung neoplasm were found in 26 cases — Eight of the cases gave no hint of the disease by the bronchoscope These eight cases, which failed to give any diagnostic help represented only 7 per cent of the 107 cases bronchoscoped

Appearance of Typical Lesion

The typical lesion as seen by the bronchoscope

TABLE 7 - LOCATIONS FROM WHICH BIOPSIES WERE TAKEN

Location	Number of Cases
Right main bronchus Entrance right upper lobe bronchus	26 5
Entrance right middle lobe bronchus Entrance right lower lobe bronchus Left main bronchus	3 11 17
Entrance left upper lobe bronchus Entrance left lower lobe bronchus	5 3 3
Trachea Total	$\frac{3}{73}$

appears as a mass of granulomatous tissue, partially or completely filling one of the main bronchi. It is most frequently covered with purulent exudate, and attempts to suction off the secretion readily cause bleeding of what proves to be a friable soft tissue mass, often covered with a layer of necrotic fibrinous evudate.

Lesions which are smaller and allow some vision beyond may be pedunculated or nodular or even flat and appear to be part of the bronchial wall with or without surface ulceration. This latter type is more inclined to a stenosing tendency of the bronchial lumen.

Cases in which neoplasm is not visible may give presumptive findings which are suggestive of the presence of lung neoplasm such as and blood from distal bronchi, bronchi with narrow and stenosed lumina, fixation and rigidity of tissues, and loss of normal respiratory mobility of the bronchial tree Broadening of the carina is generally associated with adenopathy or metastasis of mediastinal nodes Longitudinal ridges of the lining mucosa generally indicate pressure from without the bronchus Deflections and distortions of the trachea and the main bronchi together with laryngeal paralysis may indicate extension of the growth to the mediastinum and indicate the inoperability of the case Lesions found too close to the trachea, which would prohibit the proper closure of a main bronchus stump, also would indicate lack of op-

erability Biopsy

Biopsies are generally obtained from the main stem bronchi or from tissue which presents itself at the entrance of one of the main bronchi. Any tissue distal to this region can only be acquired via the bronchoscope by aspiration. This latter

TABLE 8-PATHOLOGIC CLASSIFICATION

Condition	Broncho- scopic Biopsy Number of Cases	All Cases Combined Number of Cases
Epidermoid carcinoma of the bronchus Carcinoma of the bronchus Oat cell Miscellaneous	44 19 10	61 41 13 1
Total	73	116

method is generally the only way in which peripheral types permit of a bronchoscopic biopsy

Table 7 indicates the locations from which the biopsies via the bronchoscope were taken, and Table 8 indicates the pathologic classification

Location of Tumors

Eight of the 116 cases had involvement of two lobes of the lung, the remainder had only one lobe involved (Table 9)

TABLE 9 -Number of Cabes Having Involvement of Right and Left Lobes of the Lung

 RIGHT AND LEFT LOBES OF THE LUNG		
 Location		Number of Cases
Right upper lobe Right middle lobe Right lower lobe		28 15 33
Total right side Left upper lobe Left lower lobe		76 24 24
 Total left side		48

This indicates an involvement of the right side in the ratio of 1 6 1, the most frequently involved lobe being the right lower lobe. This compares with the findings of other reporters 136

The peripheral or central location of the lesion in 116 of the cases were found to be as follows 92 central lesions, 13 peripheral lesions, and 11 both central and peripheral lesions. The peripheral types are hard to visualize via the bronchoscope This type also offers less opportunity to obtain a positive bronchoscopic biopsy Of the 13 peripheral cases, ten were bronchoscoped, and five of these resulted in positive biopsies Of the 11 cases which were classified as both central and peripheral lesions, eight were bronchoscoped, and only one resulted in a positive biopsy If we combine both the peripheral and the peripheral and central groups, we have a total of 21 cases of which 18 were bronchoscoped, and only six yielded positive biopsies This ratio is low as compared to the 70 per cent average positive biopsies obtained in the series as a whole

Metastasis

Six of the cases in this series of 116 cases had a

TABLE 10 -LOCATION AND INCIDENCE	OF MIETAFIABIS
Metastasis	Number of Cases
Mediastinal nodes Chest wall	22 9
Bones (ribs vertebrae pelvis and long bones) Brain	7 6
Pleura Bronchial nodes Supraclavicular nodes	4
Hilar nodes Trachea	4 3 3
Axillary node Abdominal wall Spinal cord	1 1 1
Total	65

positive diagnosis made by removal of tissue for examination from metastatic lesions from the following regions mammary, supraclavicular node, spinal cord, abdominal wall, and two from brain tissue All metastases noted in Table 10 with their relative frequency of occurrence were diagnosed either by bionsy, exploratory surgery or x ray findings prior to any autopey report

Improving Diagnostic Efficiency

The following steps are suggested as possible means of improving the efficiency in the diagnosis of this disease

Publicizing the need for earlier investiga tion of cough of unknown origin. The forty fiveweek period between onset of first symptoms and final diagnosis offers us one of our greatest oppor tunities to put to use the benefit of educational publicity of the need of investigation of any per entent cough

Earlier x rays Advise all patients with cough of more than three weeks duration to have chest x-rays The greater use of mass and routine

Y ray surveys

Earlier resort to the diagnostic advantages of a hospital where the internist roentgenologist bronchoscopist, and thoracic surgeon can act as a team in making the diagnosis

- Use of such aids as bronchograms, fluoroscopy body section films (planograms lamina grams), examination of sputum for blood and tumor cells, (Craver) and greater use of aspira tion specimens via the bronchoscope accompanied by the laboratory technic, as outlined by Herbut and Clerf, so essential to its success 12 13
- Repeated bronchoscopies where first attempts have failed Occasionally, the bronchoscopic view is helped by doing a pneumothorax The use of retrograde mirrors the use of proper forceps which do not macerate and destroy the structure of small tissue specimens and the cure of specimens once they are obtained are factors which help in making the result a better one.

Summary

This study and analysis of 116 cases of primary carcinoma of the lung endeavors to show the importance of the teamwork needed and emphasizes the factors which are helpful in achieving better diagnostic results

The average age in this series was fifty-five years Nine and five-tenths per cent of the pa tients were women and six per cent of the total

cases treated were Negroes

The chief symptoms of this disease as noted in this series were chronic productive cough pain, weight loss, weakness, and dyspnea with bloody sputum and frank hemoptysis gener ally late symptoms

Physical signs do not occur early in this

disease When they do occur they are generally associated with partial and eventually complete obstruction of a large bronchus I indings are usually those of duliness on percussion, together with absent or diminished breath sounds with limited expansion of the affected side

Early diagnosis can only be made by mak ing efforts to shorten the time period between the appearance of first symptoms and diagnosis (forty five weeks) and the period between the patients first seeking medical care and the final diagnosis (seventeen and a half weeks) Once the patient is in a hospital where the diagnostic team is available the time of arriving at a diagnosis is not long (105 cases averaged ten days)

I ray offers our first technical means of diagnosing the disease. In this series 85 6 per cent of the cases were given definite diagnostic

help by the roentgenologist

Bronchoscopy still offers the most direct means of making a positive diagnosis with actual ti-sue examination in the majority of cases. In this series of 116 cases, 107 cases were bronchoscoped, and 73 of these cases (70 per cent) yielded positive biopsies The 34 cases which yielded negative biodsies gave positive presumptive evidence of lung neoplasm in 26 of the cases

Biopsy of metastatic lesions and explora tory surgery together with surgery for the eradi cation of the disease such as lobectomy and oneu monectomy, were responsible for making the

diagnosis in 43 cases

Improvements in diagnosing the disease carlier can come through publicising the need of earlier investigation of chronic cough by earlier use of x ray both individually and by routine x ray surveys One should urge the earlier use of the diagnostic team facilities which are to be had at a hospital Technical factors such as greater use of bronchograms, fluoroscopy, body section films bronchoscopic aspiration specimens, and the need for repeated bronchoscopies where the first one failed, together with special care of small tissue specimens, all are factors helpful in achieving a better result

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VOLVULUS OF THE SIGMOID COLON

Victor D Woronov, M D, Bernard S Epstein, M D, and Henry W Louria, M D, Brooklyn, New York

(From the Brooklym Jewish Hospital)

VOLVULUS of the sigmoid colon surgically treated incurs a mortality rate of from 40 to 50 per cent. We should like to publish the results of our experience with a conservative treatment of volvulus which we believe will help reduce the above mortality figures. Of 485 reported cases of large bowel obstruction occurring between 1937 and 1945 at the Cook County Hospital, 37 (8 per cent) were due to volvulus of the sigmoid and presented a mortality rate of 40 per cent. Pearlman a rate of 46 per cent.

A study of these mortality figures reveals them to be largely operative In the Cook County group, of 37 operated cases reported, 28 per cent were classified as acute, presenting a twenty-four hour story with no previous attacks, 72 per cent were subacute with an average story of one hundred two hours The mortality rate of 40 per cent was apparently unrelated to gangrene, since an equal number succumbed with viable bowel as did with gangrenous bowel This may be explained by a consideration of the choice of procedures employed Eight were treated by a Mickulicz type of procedure, another had a cecostomy fifteen days prior to the Mickulicz. and still another had simple detorsion followed by a recurrence, for which a lateral anastomosis was done At a second recurrence, an exteriorization and resection were performed the above patients expired Another group of six were treated by simple detorsion with but one Five patients had a Rankin resection with three deaths Four had a cecostomy on the assumption that the condition was that of large bowel obstruction not diagnosed as volvulus, two patients died

The establishment of two guiding factors might serve to reduce the mortality in volvulus of the sigmoid colon, namely, early diagnosis and conservatism in treatment. Both of these factors are well within the scope of the surgeon working in conjunction with the radiologist.

Volvulus of the sigmoid colon may be considered in two groups acute and subacute

The acute case presents a twelve- to twenty-four-hour history of sudden onset of abdominal cramps, moderate to severe distention, and borborygmus. These patients may take up to 1,000 cc in an enema, which, however, is ineffec-

take up to 3,000 cc of enema with but a small return. Abdominal tenderness is usually minimal. The acute form tends to occur in the younger age groups.

The subacute form, occurring more frequently in the older age groups, presents a more gradual onset. There is commonly a history of previous similar episodes of crampy, lower abdominal pains and chronic constipation. These cases usually evidence severe abdominal distention and only variable abdominal tenderness. Pulse and temperature are not remarkable in either the acute or subacute cases.

Of primary importance in the establishment of the diagnosis is the x-ray, a direct plate of the abdomen often sufficing Films should be taken in both the erect and supine positions recumbent projections may be utilized in doubtful cases The characteristic finding on direct radiologic examination is the presence of a tremendously dilated loop of bowel arising from the left side of the pelvis and passing upward and toward the right As this loop reaches its summit, which in more advanced cases may actually reach the diaphragm, a sharp hairpin turn merging with the descending loop of the dilated bowel, of about the same diameter as the ascending loop. The arms of the loop disappear into the is noted pelvis, usually into the left half. Although fluid levels are at times demonstrable, very little fluid is present in the early cases. The volvulus, a mechanical obstruction, results in dilatation of the proximal colon and lesser bowel loops may be seen in these loops, but they never reach the degree of distention visible in the sigmoid, and, when present, are displaced laterally, cephalad, or caudad by the tremendously dilated sigmoid Instances have been described in which the volvulus is completely filled with fluid 2

Barium enema examination usually reveals the presence of an obstruction at the point of rotation of the sigmoid, and normal mucosal markings ¹ Crosslike or screwlike, spiral, opaque stripes at this site have been described on the post-evacuation films ¹ A valvelike action permitting entry of the barium but preventing evacuation may be present in partial volvulus

Of particular interest to us have been the reports in which volvulus has been relieved by barium enema examination or by the passage of a through the rectum past the point

of rotation of the colon . Holingren in 1941 described a nationt in whom the volvulus was reduced during a laparotomy by the passage of a tube into the rectum guided by hand beyond the volvulus. A second case is described in which the volvulus was reduced by the same maneuver, performed under fluoroscopic control without abdominal operation He mentions that successful results are predicated on a relatively loose torsion which may be present in the early stage of the condition, and that such manipulation becomes ineffectual when volvulus is present for rufficient time to result in a firmly fixed twist of the loop of bowel

In the treatment of volvulus of the sigmoid colon, operative interference at best finds the surgeon confronted with bowel that does not lend itself to any but the most conservative of procedures, that is detorsion However we do see reported all varieties of employed technics such as Rankin obstructive resection Mickulies resec tion lateral anastomosis detorsion and insertion of rectal tube tacking down of redundant mesosigmoid, and in not a few cases, eccostomy fol lowed by a one or two-stage subsequent resection Of these, nample detorsion presents the lowest mortality rates. However, it must be remem bered that volvulus is a lesson with a marked tendency to recur, doing so in 20 to 25 per cent of cases, and thus necessitating further operative in tervention which is associated with a mortality of some 40 per cent 1 It would thus indeed be of considerable aid to employ a nonoperative method of decompression in the acute or subscute phase with a view toward a subsequent elective resection during a quiescent interval phase attended by the accepted preoperative preparation that has proved of such value in colon surgery Such a method may well be the proper use of the long rectal tube as a decompressant

The tube, semingid and well-lubricated along three quarters of its length, is gently and carefully threaded along the rectum with the patient in Sliding the provi knee-chest or Sims position mal end of the tube just beyond the twist in the colon results in a sudden expulsion of gas and a dramatic decompression of the abdomen occurs concomitantly a detorsion of the colon as may be demonstrated subsequently by x ray This nonsurgical procedure, instituted before compromise of the vascular supply of the bowel, may indeed gain a vantage point, subsequently permitting adequate surgery in a well prepared patient during a quiescent interval

Case Reports

Case 1 -Mrs. L. D., aged 70 was admitted on October 1 1944 with history of obstipation of four days' duration Three days prior to admission, the

patient had a sudden attack of generalized abdomi nal pain and distention Borborygmus was audible. This patient also gave a past history of Parkinsonism of ten to twelve years duration and had been severely constipated in the past four years

Examination revealed the following stuporous, Parkinsonism apparent skin dry tongue abdomen distended and tenso. fairly moist skin glossy, and no masses palpable Bowel sounds were audible at intervals. No roctal masses or ulcer were noted Laboratory data included white blood cell count of 15 300 and urea nitrogen 28.2 mg. per cent.

A direct plate of the abdomen confirmed distention of both large and small bowel and the clinical impression that we were dealing with intestinal obstruction probably in the lower colon Accordingly. a Miller Abbott tube was introduced on the night of admission and proceeded into the upper small bowel within a few hours.

On the following morning, review of the x rays. together with an additional plate taken suggested sigmoid volvulus as the causative factor A long rootal tube, semirigid and well-lubricated, was easily threaded up into the rectum. When some 30 cm of the tube was thus introduced, there occurred a sudden expulsion of much gas and some liquid feces, associated with rapid abdominal decompression However the patient, who had been bedridden for the past four years, remained somnolent and un responsive and went on to develop a bilateral focal pneumonia on the fourth postdecompression day resulting in fatality on the nineteenth hospital day No recurrence of the originally encountered in testinal obstruction evidenced itself during this time.



Findings in volvulus of the sigmoid colon demonstrating tremendously dilated loop arising from the left pelvis

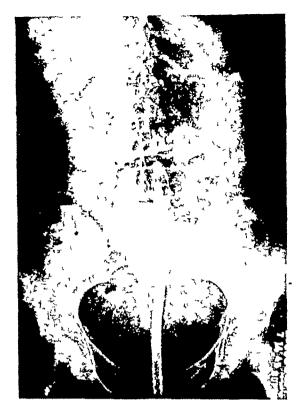


Fig 2 Rectal tube in situ with resultant detorsion and decompression of dilated colonic loop

July 14, 1945, with a history of abdominal cramps, enlargement, and obstipation of 13 days' duration without vomiting. An enema on the day prior to admission proved ineffectual. The patient had suffered with constipation for many years. There was no history of melena or frank blood in stools.

Examination revealed the following data well-nourished, middle-aged woman in evident distress, extremities cool and claiming, blood pressure 140/-100, pulse 82, temperature 99 6 F. The abdomen presented a marked generalized distention with tense wall and glistening stretched skin. There was tympany throughout. Borborygmus was both audible and palpable at intervals. On rectal examination, the ampulla was dilated, no masses or ulcerations were palpable. The impression was that of acute intestinal obstruction, probably due to sigmoid volvulus.

Following roentgen confirmation (Figs 1-3) of the above clinical impression, a well-lubricated semingid rubber tube was threaded through the rectum for about 35 cm with the patient in a Sims position. There resulted a sudden, explosive expulsion of gas and a small amount of liquid stool, accompanied by a deflation of the abdomen and complete relief for the patient. Follow-up x-ray confirmed the resolution of the intestinal obstruction, and barium clysma disclosed a markedly redundant loop of sigmoid colon. The patient was discharged to the outpatient department for follow-up care.

Case 3 —Miss K K, 23 years old, was admitted July 20, 1945, and presented a story of moderate

abdominal distention, flatulence, belching of three months' duration, and a marked tion of these symptoms attended by a and epigastric distress for three days promission. The patient gave a history of a condition prior to admission, because of blustool, roentgen studies revealed a "ki sigmoid"

On examination, the abdomen presen mendous distention, the patient, however fairly comfortable. There was tympany out and occasional audible bowel sound cally it was felt that the patient suffer volvulus of the lower colon. Proceeding assumption, a long rectal tube was in up to a distance of about 28 cm, resulting immediate rush of gas and a complete decorpt of the abdomen within the space of a few in the space of

Subsequent x-ray studies revealed the pan exceedingly redundant sigmoid of patient was discharged improved severater, with a diagnosis of partial volvuloundant sigmoid colon. Addenda revea similar episode had occurred one year but had subsided within two or three day and of prescribed pills.

Case 4—Miss E F, aged 22, was January 30, 1943 The patient gave a constipation of eight days' duration wit tion for three days prior to admission, with intermittent abdominal cramps with ing The abdomen was markedly distrympanitic There was a slight tenderileft lower quadrant Rectal examine essentially negative X-ray examinatio



Fig 3 Contrast air enema illustrating sigmoid

admission rovealed marked distention of the descending and ascending colon which on the left side ended abruptly at a lovel one inch below the crest of the ileum. Four hours following admission a rectal tube passed and produced marked relief with the expulsion of gas and watery foul-smelling stool. This continued throughout that night at intervals and resulted in complete decompression of the abdomen by morning. A baruum elysma taken subsequently outlined a markedly elongated sigmoid extending almost to the splenic flowure.

Case 5—Mr E G aged 51 was admitted January 21, 1934 The patient was acutely ill presenting a history of sudden onset of severe intermittent abdominal patns twenty four hours prior to hospitalization with associated obstipation. The patient s past history revealed occasional passage of blood-streaked stools in the past two years. There

was no weight loss or asthenia.

Examination revealed a markedly distended abdomen with moderate, generalized tendernies moranted in the left lower quadrant. Blood pressure was 130/80 pulse 80 temperature 09.2 F Blood studies revealed a hemoglobin of 70 per cent with 350000 red blood cells 1800 white blood cells with 80 per cent polymorphonuclears and 20 per cent lymphocytes. Radiographic examination of the abdomen presented marked gaseous distention of the abdomen presented marked gaseous distention of the ascending colon, hepatic flexure transverse arm, and splenic flexure with a fluid level distal thereto. The findings were interpreted as an intestinal obstruction, probably in the sigmoid. Clinically it was felt that in addition there might be a minute perforation of the bowel.

About twelve hours after admission following adequate hydration with parenteral 5 per cent glucose in saline solution the patient was operated upon. Findings revealed a volvulus of the sigmoid colon the scross of which appeared justicless and befy-red in color. There was some free fluid in

the peritoneal cavity

The sigmoid was exteriorized and regained its With the thought of avoiding normal color quickly a recurrence of volvulus in a long colon, a Mickulies type of colon resection was performed On January 23 1934, three days later the colostomy was On January 24 1934 there having been no reasonable reduction of abdominal distention and no expulsion of feces from the colostomy a rubber rectal tube was inserted in the proximal loop of the colostomy and fixed in place by a purse string suture. Also on that day the patient developed a gastric dilation requiring Levine tube drainage. From the time of operation, the patient maintained an elevation of temperature of 102 to 103 F Finally, on January 27 1934 six days postoporatively the abdominal distention and tenderness having persisted the patient expired

Necropsy revealed an adhesive peritonitis, par alytic ileus and partial obliteration of proximal

colostomy opening with impaction in the proximal

Case 6—Mrs. R. R. was admitted May 11
1045 The diagnosis was volvulus of the sigmoid
The patient was a 67 year-old woman presenting
a history of obstipation, nausen, and vomiting of
three days duration. The patient was always
constipated An enema on the day prior to ad
mission was entirely ineffectual A barium enema
performed on May 14 and 18 rovealed a marked
redundancy of the sigmoid floxure with no evidence
of an organic lesion The patient made a spontaneous recovery following barium enema and was
discharged improved on May 22

Summary

 Review of the literature reveals the surgical mortality figures in the treatment of volvulus of the sigmoid colon to be variously estimated at 30 to 60 per cent.

2 Farly diagnosis and conservativism in treatment are cited as two factors that will result in a reduction of the above mortality figures

3 The characteristic findings in direct x ray examination of the abdomen are discussed as an invaluable aid in the establishment of early diagnosis of volvulus of the sigmoid

4 The value of the long rectal tube as a decompressant in the conservative treatment of vol

vulus of the sigmoid is stressed.

5 Since conservative treatment of agmoid volvulus is attended by a recurrence in about 20 per cent of cases, the use of conservative decompression is discussed as an emergency measure that will permit subsequent elective surgical correction during an interval phase, attended by the accepted preoperative preparation that has proved of such value in colon surgery in recent years

6 Six cases are presented. In four a long tube threaded into the rectum effected a satisfactory determine of a sigmoid volvulus. In one case a barium enema resulted in a detersion. In the one case a Mickulicz resection resulted in the

death of the patient.

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A phelgmatic patient may mask grave disease by ignoring Insignificant symptoms.—Exchange

All good reasons for himoptyms should be ruled out before blaming it on lingual varices.—Archange

THE USE OF THE RECOVERY ROOM IN LOWERING' MATERNAL MORTALITY

Lewis F McLean, MD, H C'McDowell, MD, and Marvin G Sadugor, MD, Buffalo, New York

(From the Millard Fillmore Hospital)

A CONSIDERABLE number of articles have been appearing in medical journals in recent years on the subject of lowering maternal mortality and the immediate treatment of postpartum hemorrhage and shock. However, no word has been mentioned in any of these papers concerning the use of a "recovery room" as an added precaution in reducing maternal mortality, even though some hospitals are already using recovery rooms

The usual method of postpartum treatment is to leave the patient on the delivery table for one hour or to take her to a room where a nurse is to keep her under meticulous surveillance. With the nurse shortage, however, such a procedure is filled with chance and could easily be dangerous to the patient.

A recovery room, so-called because a mother is taken there promptly after a delivery, has been in evistence at the Millard Fillmore Hospital, Buffalo, New York, for more than twelve months and is most successful Since its inauguration, September 23, 1945, through to September 23, 1946, there have been 3,282 deliveries with only two deaths resulting. As this figure illustrates, the Millard Fillmore Hospital has a large obstetric service and is equipped to handle any type of delivery (Table 1)

TABLE 1 -Tyres of Deliveries

Delivery	Number of Cases
Spontaneous	408
Low forceps	2 229
Mid forceps	27
High forceps	2
Version and extraction	254
Breech	87
Embriotomy	1
Cesarean sections	
High	145
Low	21
Low cervical	86
Extraperatoneal	.8
Porro	14
Total	3 282

There were eleven cases of late postpartum hemorrhage which were detected in the recovery room and were returned at once to a delivery room for packing and treatment. Eighty-five per cent of the deliveries were operative, necessitating careful postpartum treatment which was more easily extended because of a recovery room. The Millard Fillmore Hospital records on obstetrics make this fact more emphatic. They show no decrease in maternal mortality from postpartum hemorrhage until the installation of a recovery room.

In reviewing the causes of maternal mortality, creditable mention may be made of the drop in sepsis from its long-held first place to a second

TABLE 2 -MATERNAL DEATHS-1941 TO 1946

					Deaths Due to Post- partum Hemor-	•
		Number		Ma-	rhage	
	Year	of Deliveries	Type of Delivers	ternal Deaths	and Shock	Causes of Death Other Than Postpartum Hemorrhage and Shock
٠	1941	2 255	Version and extraction Low forceps Porro Section	4	3	Pulmonary embolism
	1942	3 067	1 Low forceps 1 Breech extraction 2 Sections 2 Version and extraction	8	4	Obstruction asphyxia
	1943	3 798	1 Breech extraction 1 Spontaneous 8 Sections	10	4	Pneumonia pulmonary embolism—2 long test of labor—peritonitis peritonitis, bowel obstruction
	1944	3,128	1 Postmortem section 3 Sections 1 Low forceps	5	3	Pneumonia Cardiac—in hospital 4 hours placenta previa
	1945	3 123	2 Sections 1 Undelivered 1 Lowforceps 1 Curetage—51/2 Months 1 Spontaneous 2 Version and extraction		4	Puerperal infection—intestinal obstruction toxemia—in hospital for only few hours, pernicious vomiting, hepatic toxemia
	1946	3 282	1 Section 1 Low forceps	2	0	Intestinal obstruction and peritonitis, enteritis

DELIVERY RECORD

PATIENT & NAME			DATE							Time								
Hours After Delivery Blood Pressure Pulse		1/1	ī	11/1	2	21/1	3	31/1	4	41/1	5	51/6	6	61/1	7	71/1	8	
		-		_	-		-	_	_	_	_		_		1		1	
		-			-		_	_	_		_	-			-			
	Position	-	-	1-	J-		-	-	-	_		-	-			一		
	Fingers Above or Below Umbilious	-	-		_	_	_		_	_	_	_	_		-		Г	
Fundue	Consistency firm	1	1	1-	-	_	-	_	_	_	-	_	-	-	_		_	
	Boggy		i-		_		_		_				-		I		-	
	Profuse	-	_	-			_		_		_		Γ	_	_		_	
Flow	Moderate	_	-	-	_		_	-	_		_	_	-	_	Г		-	
	Scanty		-		_	_	_	_	_		_		_		I		_	
	Good	-			-		Γ				-		_		_		1	
Condition	Fair				_		_		_		_		_		Γ		Γ	
	n	1-	1-	1		1 ~-			_		1	1	1-			ļ		

- If the patient has any of the following conditions:
 (a) Falling blood pressure
- 1
 - Rising pulse, Boggy uterus,
 - copy userus, "rduss for or requires expression of clots, more than once or for expend condition—OALL AT ONCL.

 The resident 2. The stateding physician 2. The stateding physician 3. Laboratory for typing and cross matching statistics.

Fra. 1

and even third place as the cause of maternal death through the application of penicillin and sulfa drugs From a total of 15,371 deliveries there were 33 deaths, 18 of which were due to postpartum hemorrhage and shock, making hemorrhage responsible for more than 50 per cent of maternal deaths (Table 2) However, with the advent of the recovery room in September, 1945 there have been only two deaths One followed a cesarean section that developed an intestinal obstruction and peritonitis postoperatively as the result of several previous operations The second was a case of an acute fulminating enteritis which was not obstetric in origin occurring twelve hours after a normal delivery Most important however, there were no deaths from postpartum hemorrhage and shock in the twelve-month period

We feel that the whole essence of the idea is the time element. Most mothers are lost through apathy, delay, and an excess of optimism the most careful obstetrician may underestimate the blood lost by the mother

At the present time the recovery room is equipped with eight beds and is situated directly across from the delivery rooms so that patients can be quickly and easily transported to it im mediately following delivery The mother remains in the recovery room for eight hours, unin terrupted by visitors or well wishers.

Figure 1 will give some idea of how the recovery

room operates. During the postpartum period each patient is checked every hour by a resident or intern, and every half hour by a graduate nurse who never leaves the room during her time on At these regular periodic examinations. blood pressure, pulse respiration, temperature, position and firmness of the fundus, varinal flow. and the general condition of the patient are observed and charted

Our whole principle of postpartum treatment is to initiate reparative measures at once. Accordingly, the nurse in charge has written orders that if a woman begins to bleed, even moderately, to call the attending obstetrician and the resident in obstetrics, as well as the laboratory for typing and matching The resident, who usually arrives first has a mandate to take the mother to a delivery room if he thinks it necessary to pack her uterus and vagina tightly at once and to begin transfusions with blood or plasma, as well as to carry out other supportive therapy In case of great emergency where a delay may occur because of the time required to determine the Rh factor typing or matching, we are prepared to give Type 4-O blood with A and B substances added

We believe that packing the birth canal is the most effective means of combating postpartum hemorrhage from the relaxation of the uterus The birth canal is first thoroughly surveyed, then the cervix is pulled down and inspected, and.

if necessary, it is repaired. The uterus is explored manually to remove clots or secundines

We also advocate packing under direct observation Sterile, three-inch, plain or iodoform packs are always available. Plain packs are impregnated with a liquid antiseptic before they are introduced into the birth canal by means of a uterine-packing forceps. We have found that a wet pack introduced in this manner is more effective and is accomplished more rapidly than application of a dry pack by means of a Holmes' packer.

Conclusion

1 During the past year, through the employ-

ment of a recovery room, the Millard Fillmore Hospital has been able to reduce maternal mortality from postpartum hemorrhage from 50 per cent to zero

- 2 In these days of the grave shortage of nurses the recovery room offers an economic solution to the problem of watching the postpartum mother and effecting a prompt treatment, if the emergency so arises
- 3 It is our hope that recovery rooms may be established in all hospitals of any size all over the country so as to aid in reducing maternal mortality from postpartum hemorrhage as they have done so successfully at the Millard Fillmore Hospital in only one year's time

SCHEELE TESTIFIES BEFORE COMMITTEE

One of the first official acts of Dr Leonard A Scheele, following his induction as Surgeon General of the Public Health Service, was to testify before a congressional committee. He told the House Committee on Interstate Commerce that 54,000,000 Americans live in communities which lack full-time local health services.

In accepting his appointment Dr Scheele said

"The health of the American people and their health resources cannot and must not become a monopoly, either of governments, private enterprise, or chartable organizations. Each of these great institutions has made incalculable contributions to American health. The constituent groups and organizations within them must endure and grow in wisdom, strength, and efficiency."—I 4 M A, April 17, 1948

NEED TO EDUCATE PUBLIC ON ATOMIC ENERGY

Introduction of the world to the atomic age has produced the problem of properly educating the public on atomic energy

Recent consideration of the problem turned up a number of suggestions on the direction of an educational program of this kind, according to Dr. Herman S. Wigodsky, professional associate of the Committee on Atomic Casualties, Division of Medical Sciences, National Research Council, Washington, D.C. At the same time a number of obstacles were revealed

Dr Wigodsky addressed the spring session of the Council on National Emergency Medical Service of the American Medical Association, which opened a two-day discussion in A.M.A. headquarters in Chicago

The feeling of the conference was that an education and information program on atomic energy should be world-wide in scope and aimed at increasing the factual information of the public in order to provide a basis for reasonable, logical thought in the matter

"Among the most universally encountered obstacles to a satisfactory, continuing atomic energy information program," he asserted, "appears to be the unavailability of adequate, factual information Also the absence of a single neutral agency which could offer authoritative information on disputed questions related to atomic energy"

Dr Wigodsky said that the three most basic objectives of an atomic energy information program, as expressed by the conference, are (1) the need for relating atomic energy information to the day-to-day personal anxieties and interest of the population, (2) the necessity for making more explicit the objectives, methods of operation, and results of work of the Atomic Energy Commission, and (3) the desirability of increasing public understanding between control of atomic energy and international order—News Release, A.M.A., April 5, 1948

COMPARATIVE STUDIES WITH SOME NEWER TESTS FOR HEPATIC DYSFUNCTION

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(From the Dinsion of Pathological Chemistry and the Medical Research Laboratory Department of Medicine New York Post-Graduate Medical School and Hospital)

In the past few years extensive laboratory and clinical investigations have centered on the function of the plasma proteins, their composition and the role of the liver in their formation. This unusual interest in protein metabolism is revealed by the many studies on the importance of plasma in the treatment of shock, the effect of hypoproteinemia on wound healing the punication and therapeutic application of the vanous protein components of the plasma by Cohn and his associates, the administration of amino and sparenterally, the use of indicative isotopes in following the formation and metabolism of the plasma proteins and the recognition of the relation between prothrombin and the hemorrhago tendency in jaundleed patients

It has been accepted that the hver is concerned in the formation of plasma fibrinogen, albumin and prothrombin Recent studies by electrophoretic methods have demonstrated an increase in the gamma globulin of the serum in patients with hepatic disease They have also shown the inadequacy of the time-honored salt precipitation methods in the study of changes in the composition of the serum proteins. Electrophoretic methods surpass all others in sensitivity and accuracy, but the analysis is difficult and timeconsuming and the cost of the apparatus restricts its use to medical centers and research in stitutes Attention has, therefore, been focused on a number of flocculation tests which show qualitative changes in the composition and collor dal stability of the serum and which make up in simplicity and ease of analysis what they lack in quantitative accuracy These tests fall into two groups insofar as their diagnostic use in the study of hepatic disease is concerned

The first group comprises the formol-gel test the dilution test of Naumann, the Takata Aracaction, the magnesium chloride test of Bauer and the Weitmann reaction 1-4 These tests all show gross changes in the albumin-globulin ratio The formol-gel and the Naumann dilution tests usually do not become positive unless there is a hyperglobulinemia of 3 per cent or more, which accounts for their use in the diagnoss of such conditions as kala-axar lymplogranulomatosis, and multiple myeloma. These pro-

cedures are of less value in the study of hepatic The Takata Ara reaction and the tests of Bauer and Weltmann are poentive when a hyperglobulinemia is present, but this may be relative as well as absolute. In our experience the Takata Ara reaction has been the most satisfactory of this group for routine use. A positive test usually indicates a reversed albumin-globulin ratio and this reversal may be due to reduction in the albumin as well as to an increase in the globulin fraction As such, the procedure is not a specific test of henatic insufficiency However, when other causes of alterations in the serum proteins are excluded on clinical grounds or when gyidence of chronic hepatic disease. ie, cirrhosis is present, then a positive Takata Ara reaction is of confirmatory value,

The tests of the second group are of greatest value as indicators of acute parenchymal damage to the liver. The best known and most widely used procedure of this type is the cephalin cholesterol flocculation test of Hanger? More recently the colloidal gold reaction and the thy mol turbidity test of Maclagan have been added to the group.

The present report is based on a comparative study of these latter three procedures in 169 patients with and without hepatic disease. In all, 232 determinations were carried out amul taneously * The cephalin-cholesterol flocculation test was performed according to the procedure described by Hanger 7 8 The cephalin cholesterol antigen prepared by Difco was found to be relatively stable and of a satisfactory degree of sensitivity Merthiolate (1 500) was added to the standard solution to prevent bacterial contamination. Exposure to sunlight was avoided by keeping the tubes in the dark until Disregarding these precautions may lead to false positive tests.12

Results were read at the end of twenty four hours. The colloidal gold reaction of the serum was done according to the method described by Gray. The thymol turbidity test was carried out by the method of Maclagan. 18,11 The procedure was modified to the extent that 0 1 cc of serum was added to 6 cc. of thymol buffer solution. The degree of turbidity present at the end of one-half hour was measured by comparison with the formazine turbidity standards of Lingsbury. 12

^{*}The authors are indebted to Miss Else Front, B.A and Mrs. Estelle Goldman for technical assistance.

The Kingsbury standards were calibrated to read in terms of mg of protein per 100 cc of urine. The results of the thymol test are expressed in arbitrary units obtained by dividing by ten the mg of protein equivalent to each Kingsbury standard.

Results

Table 1 shows the results obtained in a control

TABLE 1 -- OBSERVATIONS ON TEN NORMAL PERSONS

Case Num- ber	Icterus Index Units	Cephalin- Cholesterol Flocculation	Colloidal Gold Reaction	Thy mol Tur bidity Units
1	8	± Negatave	1	$\begin{smallmatrix}1&0\\2&0\end{smallmatrix}$
3	11	Negative	4	3 5
4	8	,, ±	1	20
5 6	4	Negative Negative	Negative Negative	$\begin{smallmatrix}0&5\\1&5\end{smallmatrix}$
7	ñ	Negative	Negative	រំ ព័
8	ď	++	1	ÕŠ
.9	8	Herative	Negative	1.5
10	u	Megrano	1	10

series of ten apparently normal individuals. The icterus index was 8 units or below, the cephalincholesterol flocculation was no greater than one plus, the colloidal gold reaction was under 3. and the thymol turbidity was less than 4 units in nine of the ten cases studied. This corresponds with the normals reported by the authors of the various tests Case 3 with an icterus of 11. a gold curve of 4, and a thymol turbidity of 35. all of which were borderline readings, occurred in an intern in good health who apparently was an example of congenital hepatic dysfunction (simple hyperbilirubinemia, simple familial cholemia) The inclusion of this case in a series of normals may be open to question In Case 8. the cephalin-cholesterol flocculation was two plus In this laboratory such results are found occasionally in apparently normal individuals, without corroborative evidence of hepatic injury such a finding is not considered significant

All three tests were positive in the majority of cases with acute infectious hepatitis studied (Table 2) In Cases 1 and 8 in which multiple readings were made, the tests returned to normal

TABLE 2 —OBSERVATIONS ON NINE PATIENTS WITH IN-PECTIOUS HEPATITIS

Case Num- ber	Icterus Index Units	Cephalin Cholesterol Flocculation	Colloidal Gold Reaction	Thymol Tur bidity Units		
1	63	++	4	6.0		
-	60	++	4	6 0		
	32	· +	1	2 5		
2		++++	5	22 5		
3	11	++	5	70		
4	75	++++	5	15 0		
5	47	Negative	Negative	30		
6	174	++++	5	75		
7	13	#	5	6.0		
	12	±	5	60		
8	18	+++	4	80		
	7	Negativo	3	2 5		
9	45	+++		22 5		

as the patients recovered While these procedures showed parallel changes in general, there was no definite correlation between the readings of any two tests or between the tests and the acterus index Case 5 was a discharged soldier of twentysix years with a marked laundice and an enlarged liver (duration of one week) at the time of admission to the hospital He recovered rapidly and was well when discharged from the hospital The clinical course was that of an acute hepatitis The normal cephalin-cholesterol flocculation, colloidal gold reaction, and thymol turbidity tests associated with a slightly elevated alkaline phosphatase (not recorded in Table 2) suggest, however, that the patient may have had a mild cholangiolitis rather than a true parenchymal hepatitis

TABLE 3 —OBSERVATIONS ON 32 PATIFIETS WITH CIRRIOSIS

TABLL	3 — UBBF	of the Livi	ratifats witi	CIRRIOSI
Case Num ber	Icterus Index Units	Cephalin- Cholesterol Flocculation	Colloidal Gold Reaction	Thy mol Tur- bidity Units
1	27	+++	4	6 0
•	22	444	4	őŏ
2	14	++++	4	14 0
	14	++++	5	14 0
3	100	++++	5	20 0
	100 150 137	1111	Ď E	13 0 0 0 5 0 5 0 0 0 0 0 0 0 0 0 0 0 0 0
4	7	$\tau\tau \tau \tau \tau$	ž	6 0
5	Š	++	â	žδ
6	7 8 19	++++	4	60
4 5 6 7 8 9	в	++		35
8	7	. +	Negativo	2 0
10	10 10		4	10 0
ii	11	IIII	5	3 0
11 12	Î8	+	ĭ	ĭŏ
13 14 15 10	8 9 12 30	++++	5	14 Ô
14	12	++++	5	7 5
15	30 6	+++ +	4	4 0
17	11	IIII	Ð ∡	7 B
17 18 10	11 130	7111	2	5.0
10	15	++++	5	15 Q
	14	++++	5	15 0
20 21	6 46	. +++	5	14 0
21	46	++++	5	27 0
	40 20	1. T. T. T.	4.	150
	37	IIII	4	15 0
	40 38 37 37	++++	į.	27 0 15 0 23 0 15 0 10 0
22	80	· · · · ±	4	5 5
	33	±	5	6.0
$\frac{23}{24}$	7 30	+++	5	8 0
24	30 10	3. 1. 1. 1	Ş	7 0
25 26	12	IIII	5	7 5
27 28	18	1111	ř	5 5 6 0 8 0 7 0 8 0 7 5 22 5 15 0
28	23	· + + +	Š	15 0
29	10 12 18 23 38 33	(±	4 5 5 5 5 4 5 4 4 4 5 5 5 5 5 5 5 5 5 5	0 5
30	33	+++	4	50
31 32	12 18	111 <u>+</u>	4	13 0 0 5 0 5 0 0 0 0 0 0 5 0 5 0 0 0 0 0
	10	777	4	10 0

A group of 32 cases of hepatic cirrhosis is reported in Table 3. All stages of cirrhosis are represented. The majority were jaundiced to a greater or lesser degree as indicated by the interus index. In 21 patients, all three tests were positive, in seven, one or more tests were positive, and in only four were all procedures negative.

The results obtained in 13 cases of obstructive jaundice are shown in Table 4. The three pro-

TABLE 4 -OBSERVATIONS ON 12 PATIENTS WITH OBSTRUCTIVE JAUNDIOS

Case Number	Diagnosis	leterus Index Unita	Cephalin Cholesterol Flocculation	Colloidat Gold Reaction	Tl vniol Turbidity Units
1 3 4 5 6 7 7 5 9 10 11 12 13	Carcinoma of the panereas Carcinoma of the panereas Carcinoma of the panereas Carcinoma of the natureas Carcinoma of the natureas Carcinoma of the panereas Carcinoma of the panereas Carcinoma of the panereas Carcinoma of the paneleas Carcinoma of the moult atono Calculus (common duct atono) Calculus (common duct atono) Calculus (common duct atono) Calculus (common duct atono) Calculus (common duct) Calculus (common duct)	18 18 18 18 115 58 187 40 138 115 83 63 16 83 83 83	ricesulus +++ N galive ++++ Negalive Negalive Negalive Negalive ++ Negalive ++ Negalive +++ Negalive +++ ++ Negalive +++ Negalive	Nogativo Nogativo Negativo Vegativo Negativo Negativo Negativo Negativo Negativo Negativo Negativo Negativo Negativo	00 8 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
		1	‡	i	3 5

cedures were negative in nearly all of these patients. One case of postoperative structure of the common duct (Case 13) showed positive results. A case of carcinomi of the head of the pancreas (Case 1) developed a positive cephalin-cholesterol flocculation test after any weeks or more of bilary obstruction. One patient with stone in the common duct and bilary obstruction for eight weeks (Case 8) also gave positive tests. In these, the long-standing obstruction apparently had produced secondary hepatic dumage.

Eight cases of carcinomatesis of the liver are reported in Table 5. In all of these the liver was examined at operation or autopsy and found to show secondary carcinomatosis of varying degree. In this disorder the results of the tests were variable. Five of the eight showed positive cephalm cholesterol flocculation reactions. In only one was the colloidal gold test positive. The thymol turbidity test was positive in five. In this group, greatest variation in the responses of the three tests was noted. In only two (Cases 3 and 5) were they uniformly negative.

A group of miscellaneous cases is shown in Table 6 Case I was a nurse twenty-two years old who was admitted to the hospital because of alidominal pain nauson vomiting, and jaundice The three tests indicated severe hepatic damage Acute cholecystatis and cholelithiasis were found Following cholecystectomy the at operation icterus index slowly returned to normal tests repeated five months later still showed marked residual hepatic damage. The patient apparently had a complicating cholangitis at the time of operation, and secondary biliary cirrhosis had ensued Two cases of sarcoidous with hepa tic enlargement (Cases 2 and 3) showed positive tests. One case of lymphosarcoma (Case 5) and one of lymphatic leukemia (Care 6) gave positive tests Malaria is of interest because of the presence of a positive cephalin-cholesterol flocculation test during the active stages of the disease This has been reported by the present authors

and by others and of itself is not evidence of hematic damage 14-17

Ten cases of decompensated heart disease with passive congestion of the liver were also studied (results not tabulated). The liver was enlarged in all and in one instauce had been palpable for ten months. All three tests showed normal reactions in this group of patients. A variety of other miscellaneous conditions were tested. They in clude many disease processes not related to the liver such as chronic glomerulonephritis, asthmacute infections. Hodgkin's disease, etc. The results were within the limits of normal in all

Comment

The cephalin-cholesterol flocculation test, the colloidal gold reaction and the thymol turbidity test are of value as indicators of hepatic injury. They tend to be positive in cases of acute hepatitis and in portal cirrhosa and tend to be negative in cases of uncomplicated obstructive jaun dice. Accordingly, they are of distinct value in the differential diagnosis of jaundice. A definite diagnosis however, cannot be made on the basis of these tests alone, for they may be negative in mild cases of hepatitis or in mactive cases of

TABLE 5.—OBBERTATIONS ON EIGHT PATIENTS WITH CAR CHOMATORIS OF THE LAVER

Case Nu + ber	leterus Index Unity	Cephalin Cholesterol Flocculation	Colloidal Gold Reaction	Thymol Tur bidity Units
1	107	+	4	4 5
_	100	+++	4	4 5
2	52 94	I	÷	50 35
	137	I	i	80
	115	+++	î	3 5
	125	+++	ī	50
_	120	+++	1.	3.8
3	58	+	Vegative	0 5
3	15	++++	Negative	7 0 1 0
	19	=	Negativa	iŏ
	12	+	Negative	1.0
6	100	+++	1	4.0
	136	++	1	40
,	136	11		5 O 2 O
•	33	+II	-4	3 0
	100	* · · · · ±	Negative	8 0

The Kingsbury standards were calibrated to read in terms of mg of protein per 100 cc of urine. The results of the thymol test are expressed in arbitrary units obtained by dividing by ten the mg of protein equivalent to each Kingsbury standard.

Results

Table 1 shows the results obtained in a control

TABLE 1 -OBSERVATIONS ON TEN NORMAL PERSONS

Case Icterus Cephalin Colloidai S Num- Index Cholesterol Gold bi	iymol Fur- dity, Juits
1 8 + 1	10
2 6 Negative 1	20
3 11 Negative 4	3 5
	2 0
	0.5
6 8 Negative Negative	1 5
7 G Negative Negative	10
8 ++ 1	3 5
9 8 ± Negative	1 5
10 6 Negative 1	10

series of ten apparently normal individuals. The icterus index was 8 units or below, the cephalmcholesterol flocculation was no greater than one plus, the colloidal gold reaction was under 3, and the thymol turbidity was less than 4 units in nine of the ten cases studied. This corresponds with the normals reported by the authors of the various tests Case 3 with an interus of 11. a gold curve of 4, and a thymol turbidity of 35. all of which were borderline readings, occurred in an intern in good health who apparently was an example of congenital hepatic dysfunction (simple hyperbilirubinemia, simple familial cholemia) The inclusion of this case in a series of normals may be open to question In Case 8. the cephalin-cholesterol flocculation was two plus In this laboratory such results are found occasionally in apparently normal individuals, without corroborative evidence of hepatic injury such a finding is not considered significant

All three tests were positive in the majority of cases with acute infectious hepatitis studied (Table 2) In Cases 1 and 8 in which multiple readings were made, the tests returned to normal

TABLE 2 —OBSERVATIONS ON NINE PATIENTS WITH IN PRECTIOUS HEPATITIS

Case Num- ber	Icterus Index Units	Cephalin- Cholesterol Flocculation	Colloidal Gold Reaction	Thymol Tur- bidity, Units
1	63	++	4	6 0
-	ĞÕ	44	ā	őŏ
	32	, †	ī	2 5
2		++++	5	22 5
2 3	11	`` • •	5	7 0
ă.	75	++++	5	15 Ŏ
5	47	Negative	Negative	ŏš
6	174	++++	5	
7	13	· · · · ±	5	
•	12	=	5	
8		$++\overline{+}$	4	
-	7	Negative	Š	
9	45	+++	-	22 5
7 8		+++	5 5 5 4 8	

as the patients recovered While these procedures showed parallel changes in general, there was no definite correlation between the readings of any two tests or between the tests and the icterus index Case 5 was a discharged soldier of twentysix years with a marked jaundice and an enlarged liver (duration of one week) at the time of admission to the hospital He recovered rapidly and was well when discharged from the hospital The clinical course was that of an acute henatitis The normal cephalin-cholesterol flocculation, colloidal gold reaction, and thymol turbidity tests associated with a slightly elevated alkaline phosphatase (not recorded in Table 2) suggest, however, that the patient may have had a mild cholangiolitis rather than a true parenchymal hepititis

TABLE 3 —OBSFRIATIONS ON 32 PATIENTS WITH CIRROSIS
OF THE LIVER

		O) THE LIVE	FR	
Case Num	Ictorus Index	Cephalin- Cholesterol	Colloidal Gold	Thymol Tur- bidity,
ber	Units	Flocculation	Reaction	Unita
I	27 22	+++	4	0 0
	22	+++	4	60
2	14	++++	4	14 0
•	14	++++	5	14 0
3	100 150	††† †	õ	20 0 13 0
	197	TTIT	į.	13 0
4	137	$\tau\tau 11$	Reaction 4 4 5 5 5 5 4 3 4 5 Negative 5 1 5 4 5	13 0 13 0 6 5 6 0 3 5 6 0 3 5 2 0 10 0 3 0 14 0
4 5 6 7 8 9 10 11 12 18	ė.	11	Ž	3 5
Ğ	19	++++	4	8 Ö
7	6	' · + +	ŝ	3 5
8	7 10	· ±	Negative	2 0 5 0
. 9	10	++	4	50
10	10	††† †	5	10 0
11	11	++++	5	3 0
12	8	111	1	11 0
14	19	IIII	ē	7 6
14 15	12 30	IIII	4	1 0 14 0 7 5 4 0 7 6 5 0 15 0
îŏ	Ğ	IIII	Ě	7 6
17 18	11	++++	å	5 Ŏ
18	130	` } } }	ž	50
10	15	++++	5	15 Q
	14	++++	5	15 0
20 21	6	+++	5	14 0
21	46	++++	5	27 0
	46 38	, †††	4	15 0 23 0
	37	IIII	5	15 O
	37	IIII	3	10 0
22	37 37 30	4-	7	5 6
	33	‡	Ē.	ő ő
23	7	++∓	5	8 0 7 0
24	30	· · · +	Š	70
25 26	10	++++	5	80
20	12	++++	5	7 5
27 28	18	++++	5	22 6
28 29	23 38	+++	45425555545444555555555555555555555555	12 6
30	38 33		Negative	U 3
31	12	TTI	4	3 0
32	12 18	4.4.I	4	5 6 0 8 0 0 8 7 0 0 5 6 0 0 5 0 0 5 0 0 5 0 0 0 5 0 0 0 0
		6.4.4.	7	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

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Case Number	Diagnosia	I teru Index Unita	Ceptuille- Cholestérol Flocculation	Coll idal Gold Reaction	Thy mol Turbidity Units
1 2 3 4 5 6 7 8 9 10 11 12	Carcinoma of the pancreas Carcinoma of the pancreas Carcinoma of the pancreas Carcinoma of the pancreas Carcinoma of the pancreas Carcinoma of the pancreas Carcinoma of the pancrea Carcinoma of the pancrea Carcinoma of the pancrea Calculus (common duct atono) Calculus (common duct atono) Calculus (common duct tono)	18 18 18 18 18 18 18 19 18 18 18 18 18 18 18 18 18 18 18 18 18	+++ Negative +++ Negative Accastive	Nogative Negative Negative Negative Negative Negative 2 1 Negative 2 2 1 Negative 2 1 Negative	000000000000000000000000000000000000000

cedures were negative in nearly all of these partients. One case of postoperative structure of the common duct (Case 13) showed positive results. A case of carcinoma of the head of the pancreas (Case 1) developed a positive cephalin-cholesterol flocculation test after six weeks or more of biliary obstruction. One patient with stone in the common duct and biliary obstruction for eight weeks (Case 8) also gave positive tests. In these, the long-standing obstruction apparently had produced secondary kepatic damage.

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TABLE 5 .- OBSERVATIONS ON EIGHT PATIENTS WITH CAR-

Case Num bar	leterus Index Units	Cophalin Cholesterol Flocculation	Colloidal Gold Reaction	Thymol Tur bldity Unlts
1	107 100		•	4 5
2	52	**I	ì	3 6
-	94	+	i	
	137	+	1	3 5 5 0 3 5
	115 125	ĪĪĪ	1	3 S
	136	III	i	3 5
3	3	===	Vegative	0.5
4	58 15	++++	2.,	7 0
٥	19	土	Negative Negative	10
	12	1	Negative	iŏ
6	100	+++	1	40
	136	++	1	4.0
7	136 83	II	7	\$ 0 • 0
•	35	+++	1	30
8	100	· · ±	\ogative	δŎ

TABI E 6 -OBSERVATIONS ON EIGHT PATIENTS WITH MISCELLANEOUS DISORDERS

Case Number	Dingnosis	Icterus Index Units	Cophalin- Cholesterol Plocculation	Colloidal Gold Reaction	Thymol Turbidity, Units
1	Acute cholecystates with residual liver damage following cholecystectomy	43 20 14	+++ +++ +++	5 5 5	10 0 12 0 10 0
		14 13 7	+++ +++ +++	5 5 5	12 0 12 0 8 0
2 3	Sarcoidosis Sarcoidosis	13 15 6	+++ ++++ -+++	5 5	7 0 8 0 6 0
4 5 6	Familial hemolytic jaundice Lymphosarcoma Lymphatic leukemia	17 10 7	++++ +++ +++	3 5 3	3 0 10 0 6 0
7 8	Amebic abscess of liver Pneumonia	9	Negative +++	3 5	7 0

cirrhosis Moreover, positive reactions may occur in obstructive jaundice when the disease complicated by cholangitis, long-standing hydrohepatosis, or by carcinomatous invasion of The three tests tend to parallel each other in the same type of disease, but not infrequently discrepancies are noted in the results of the individual tests

Hanger and his coworkers have shown that a positive cephalin-cholesterol flocculation reaction is associated with changes in the serum proteins 18 Either an increase in the gamma globulin fraction of the serum of a change in the stabilizing effect of the serum albumin or a combination of both factors will produce a positive test Maclagan and Gray consider a positive colloidal gold reaction primary evidence of an increase in the gamma globulin fraction of the serum Maclagan reported that a positive thymol turbidity test was due to the presence of a specific lipoprotein complex in which gamma globulin was one compo-Hangar agrees that lipids are essential for a positive thymol turbidity reaction, but he believes that another abnormal constituent of the serum, possibly protein but perhaps not gamma globulin, 18 essential 19 Our own experience has indicated that positive thymol turbidity reactions may occur during postprandial hyperhipemia, in di ibetic coma with hyperlipemia, and in essential vanthomatosis

It is evident from these considerations that while the changes in the three tests may parallel one another in an individual patient, they do not indicate identical changes As such, they supplement rather than supplant each other three, the colloidal gold solution is the most timeconsuming to prepare, and the test frequently shows changes which are difficult to interpret in the light of our present chinical knowledge. The cephalin-cholesterol flocculation test is simple to perform, and all workers agree that it is a valuable procedure for the estimation of hepatic Like the cephalin-cholesterol reaction, the thymol turbidity test has the great advan-

tage of simplicity, and it can be used also as a bedside or office procedure Moreover, the solutions are stable and uniformly sensitive ings can be made in one-half hour and are semiquantitative This procedure, therefore, deserves wide acceptance and use

Summary

Flocculation tests, particularly the cephalincholesterol flocculation test of Hanger, the colloidal gold reaction of Gray, and the thymol turbidity test of Maclagan are of value in the study of hepatic disease and in the differential diagnosis of jaundice

Occasional discrepancies, the explanation of which is only partially understood, occur between these three tests, but, in general, they supplement rather than supplant each other

The simplicity and rapidity of the thymol turbidity test together with its sensitivity recom-

mends it for widespread acceptance and use

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THE ASSOCIATION OF PSYCHOSOMATIC DISORDERS AND THEIR RELATION TO PERSONALITY TYPES IN THE SAME INDIVIDUALS

Eu Moscicowitz M.D., and Mata B. Roudin. New York

THE purpose of this study was to note how frequently disorders that are conventionally regarded as psychosomatic in origin are associated in order to determine, first the relation of the fundamental type personality to their incidence and, second, the relation of one psychosomatic disorder to the other. The following maladies were selected essential hypertension, Graves' syndrome, peptic ulcer nonspecific ulcerative colits, spastic colon and mucous "colitis" and cardiosnasm.

In previous communications one of us submitted the thesis that psychosomatic diseases are the result of the impact of two factors an under lying personality type and an environmental in sult, and that the disorder represents a hyper kinesis of a dominant physiologic function and sometimes of subsidiary ones 1-2 For example, in essential hypertension there is an exaggeration of the normal intra arterial pressure in Craves' syndrome, the normal basal metabolic range and pulse rate are exaggerated in peptic ulcer the normal acidity of the gastric juice in colonic disorders, the normal tonicity peristals and secretion and in cardiospasm, the normal tonicity of the cardine sphincter The environmental insult is one that dislocates the emotional life either temporarily or over a prolonged period it may be sudden, repetitious or catastrophic

These two factors may be compared to the tunder and the spark. This duality of causation of discussed processes is not distinctive of the psychosomatic disorders but runs threadlike through most discussed processes as for instance the infective and allergic discusses. They may be compared also to the intrinsic and extrinsic factors of Castle. It is for this reason that the study of constitution has been revived. However, we believe that a broader concept of constitution must be invoked than the one which is conventionally limited to physical attributes.

In our view, a constitution may be physical, or it may be entirely psychologic. Often it is both. To what extent the physical attributes are sequential to psychologic or to genetic factors, that is, whether they are acquired or foreordained, is still a much labored study. This problem also has a bearing on how far the purely psychologic constitution is genotypic or phenotypic. A discussion of this topic is beyond the scope of this communication, but thus far the results of psychoanalytic technic and the results of child study appear to show that this constitution is

largely the result of influences that began at birth. The study of psychosomatic diseases in monozygotic twins would be enlightening, but the number of reported cases is still too small to permit any deduction 4.5. Some recent studies of psychosis in monozygotic twins appear to show that heredity is not as important as environment in its production 4.7.

One of the largest problems in psychosomatic diseases is the cluedation of the vanous mechanisms whereby these prolonged exaggerations of normal functions are transmited into organic disease. That this is largely mediated through the hypothalamus and autonomic nervous system is well accepted. The concept of hyperkinesis implies the necessity of a biologic and not a static study of the psychosomatic disorders. One of us has made attempts in this direction.

The typology of the psychosomatic disorders, as in the broader field of psychiatry, has been largely governed by the point of view, whether it be anthropomorphic behavioratic psychoana lytic, "gestait" sociopsychologic etc Each has some merit and has proved useful but only for purposes of the broadest classification

To define a personality in one word such as introvert or extrovert, pyknie or asthenic, narcissistic or schizoid aggressive or submissive, is hardly satisfactory for our purpose, since such terms are too indefinite Personalities are not sharply contrasted in the sense of plants and and mals but represent aggregates of units which differ not so much quantitatively but in the degree of dominance of certain attributes and in their potentialities for compensation and decompensation. For this reason we have been clustic in our typology, and have resorted to a synthesis and the elaboration of a composite picture. Moreover in some of the psychosomatic diseases we have availed ourselves of anthropomorphic characters that have proved valid in a large proportion of affected individuals. While respecting psychoanalytic technics profoundly, we feel that these interpret only the mechanisms whereby the type of personality came to fruition our purpose it is only the end result and not the symbolic interpretation that interests us.

Essential Hypertension

It must be stressed that an apparent essential hypertension may have an anatomic background. We refer for instance to cases following congenital stenosis of the aortic istimus, adrenal blasto-

mata, lead poisoning, and Cushing's syndrome These we have excluded from our study

In 1919, one of us tried to describe the prevailing type personality in patients with essential hypertension 8 These individuals are prematurely old mentally Unlike children who live in the immediate present, they look forward with anxiety to the future, a symptom of a profound economic or social insecurity, and live intensely and desperately to achieve their aims Dominating aggressive qualities, therefore, loom large in their activities and are sometimes even sudistic in their intensity These patients are unwilling to learn how to play because to do so might shunt their strivings to achieve security They lack hobbies or avocations They do not believe in holidays, and they do not indulge in sports They are labored in thought and action lean toward intolerance They have no sense of make-believe, and their imagination, except in so far as it is employed for attaining security, is undeveloped Their humor is inclined to be sadis-Many have attained success, but many have had success slip from their grasp, mostly those in whom the struggle for existence begins early and largely represents a battle to fill the

Anthropomorphically, these patients tend to be overweight, since they exercise little, usually overeat, and indulge in alcohol to bring release from their inner tensions. Furthermore, they lack the grace and spring and clan of the athlete Most belong to the sthenic or to Kretchmer's schizothymic types.

Obviously, all hypertensive individuals are not of this pattern (as we shall show) nor do all such individuals develop essential hypertension must be remembered, however, that essential hypertension has a long period of incubation, so to speak, and it has been our frequent privilege to note after fifteen to twenty years of observation the incidence of hypertensive disease in an individual who was true to type Obviously, environmental influences play a dominant part in the time incidence. We believe the appalling increase of essential hypertension is a by-product of modern civilization burdened with its increasing social and economic stresses and Although oftentimes one observes in strains hypertensive patients transient increase in pressure following psychologic trauma, one rarely sees a sudden onset of the malady after such episodes, as one frequently notes the development of disease in Graves' syndrome Hypertensive disease is nearly always insidious in onset, and the entire life perspective of such individuals may be regarded as the psychologic trauma The transition of essential hypertension into the catastrophic forms of cardiovascular disease is familiar

Essential hypertension, therefore, is the result of a background and an insult Either factor alone is insufficient

Graves' Syndrome

In previous papers, one of us tried to show that Graves' syndrome represented the mature phase of a series of larval disorders that have received different eponyms in the past, such as neurocirculatory asthenia, autonomic imbalance, Basedow's disease, formes frustes, etc., the proof being that forward transitions are often observed and, likewise, backward transitions to the larval forms, either as the result of spontaneous remission or of treatment * 10

We do not regard the basal metabolic rate as a diagnostic measure but rather as a measure of the hyperthyroid component and, therefore, as an inder of activity. The common denominator is a fairly sharply defined personality If the individual has been observed before the onset of the disease, or if his personality is reconstructed, one is impressed by the extraordinary emotional sensitivity These are extremely touchy and temperamental people and respond to the environment like an Aeolian harp A look or a harsh word upsets them for a protracted period. They are shy and introverted There is little of give and take in their conversation, since they are only interested in their own reactions. Their thoughts move swiftly, and this is reflected in rapid and restless bodily movements Their moods swing unduly between ecstasy and depression, and these swings if exaggerated and fixed may even lead to a real manic depressive psychosis Such psychoses are rather frequent in Graves' syndrome 11,12 The individuals are day dreamers, imaginative, and have strong leanings toward the mystic

In this group one finds the artists, the poets, the writers, the actors They are sensualists, narcissistic, and live on stimulation, emotional, physical, and even chemical They are usually fussy, overconscientious, and pass through life seeing the leaves and not the trees Emotionally they are immature, and sexual frigidity, especially in women, is exceedingly common In men, impotence, homosexuality, or some other difficulty in sexual adjustment is the rule

Psychoanalytically, one is impressed by the frequent story of parental overprotection in childhood, nearly always maternal, which expresses itself in adulthood by a profound maternal fixation. The overprotection accounts for the high incidence of this malady in females, because in our social organization they are more subject to overprotection than males. Overt aggression is, on short acquaintance, not manifest, on the contrary, the first impression is one of submissiveness. When their motivations are studied, how-

ever, one finds that they possess what Lovy calls a "defendent aggression", they will resort to extreme means to maintain their cocoon of over-protection. The siblings often reveal the same type, and in no disease is the study of the family so fruitful. This personality remains oven after the "cure," and is always a potential factor in producing a recurrence.

There is no characteristic anthropomorphism They incline toward leanness rather than overweight owing to the heightened metabolic rate Under environmental stress the eves become starry, the face becomes animated or fearful or flushes they laugh or ery easily and there is usually increased sweating the fingers tremble.

The disease is ushered in by a psychic insult for which the individual is usually unprepared, a fire, a robbery, a death, especially of the mother, a sudden economic loss. We have seen a large number of Jewish refugees at the Mt. Sinai Hospital in whom the disease was traceable to porsecution. Less often, the disease arises from a prolonged or a number of reiterated insults, and the transition from the larval state to the fully developed form is under such circumstances indefinable.

Peptic Ulcer

This type of individual is a combination of physical and psychologic characters. The physical have been stressed by Draper and AlcGraw ¹⁴. They have the "lean and hungry look of Casus, the expression is hard and tense, the eyes are deep and sullen, the mouth is firm, the facial lines are sharp the masseter muscles are prominent and the jaws are sharply angled. They are usually cyanotic and show a tendency to crythremia. To what extent these physical characters are the result of what Alexander calls their 'oral aggression" or of genetic factors we are not prepared to say ¹⁴.

Psychologically these individuals are charactenzed by what Levy terms a sadistic or masochistic aggression They possess a deep desire to mold their environment to dominate persons and situations They are ruthless in trying to attain their ends and when they fail they bear a tremendous inward resentment. As a consequence they are exceptionally rigidly minded. They are all or nothing folk, harboring strong grudges and equally strong likes The latter, however are subject to change without notice They give as little as possible of themselves are self-conscious and inhibited in action and speech. They express themselves violently on every subject for there is nothing of the "medias res" in their make-up They are often paranoid in the intensity and fixity of their hates, and this is associated with a conanderable degree of solf-appreciation

narcissism, unlike that of the individual with Graves' syndrome where it is expressed in some form of self revelation, here manifests itself in self immolation

As in Graves' syndrome, the onset of the discase, or more usually the recurrence dates from an emotional conflict, the illness or death of some one dear, economic distress, an unwanted pregnancy, the development of a powerful hate, a thwarted love affair, etc. The incidence of poptic ulcer in both American and British armies in World War II was enormous, and it was agreed by most observers that this was largely due to resentment against military life

Mucous Colitis, Spastic 'Colitis, and Nonspecific Ulcerative Colitis

We have grouped these disorders together, because fundamentally the type of personality is the same although in our experience those afflicted with the ulcerative variety reveal a more pronounced form Although some question has been raised as to whether mucous or spastic "colitis" ever passes into nonspecific ulcerative colitis. nevertheless, the frequency with which one can unearth a history of mucous spastic "colitis," alternating constipation and diarrhea, irritable colon, etc often dating back to childhood, makes us feel that, in some cases at least these represent larval phenomena. Mucous "colitis" and spastic "colitis" are probably synonymous maladies, mace they alternate in the same individual. There are no distinctive anthropomorphic characters in these disorders

Psychologically, one is impressed by their submissiveness they are utterly dependent indi viduals. They reveal minor compulsions in the form of neatness meticulousness, and overconscientiousness Phobias are common, especially in connection with crowds, and depressive and defeatist tendencies are shown. They are soft and weak willed, narrow horizoned, and emotion ally immature. Sexual maladjustments are exceedingly common as indicated by the frequency with which nonspecific ulcerative colitis occurs during or immediately after a honeymoon The childhood history of these individuals also reveals parental overprotection, and, as in Graves syndrome they are frequently only or favorite children Aggression in any form plays but a very inagnificant role in their mental make-up, and when traces of it are discernible, it is of a depen dent and not a sadistic nature Psychoanalytic ally, Alexander contrasts the colonic type as dependent anal receptive and oral aggressive in contrast to the peptic ulcer type characterized by an "inner rejection of passive reception and oral aggression tendencies. Alexander stresses the symbolic use of feces as an expression of hostility Others classify such individuals as anal

As in other psychosomatic diseases, the onset or exacerbation of the disorder is often heralded by an emotional insult, but as a rule the insult is not sudden or catastrophic and follows a life situation into which the patient finds himself propelled more often than following resentment against an individual

Cardiospasm

We regard cardiospism as a psychosomatic disorder, since there is abundant testimony that it is initiated by a psychologic trauma 16-19

Winkelstein reports eight cases in which a psychologic insult occurred immediately preceding the onset 18 In two instances psychotherapy affected a cure More recently, Weiss reported nine cases in which the cardiospasm arose after an emotional conflict, often occurring in puberty in individuals whose early life presented evidences of personal difficulties 19 He also found that other members of the family showed neuroses Parent-sibling relationships are senously dis-At first the symptoms are intermittent, later, they are permanently established Exacerbations occur which frequently can be correlated with first psychic insults Weiss believes that the physical disorder represents symbolically a compromise between the gratification of certain impulses and their rejection by another part of the personality He regards cardiospasm as the result of the interaction of a predisposition and a psycluc factor

Weiss and others regard psychotherapy as curative in early cases ¹⁸ ¹⁹ Cardiospasm was frequent during World War I and in the recruits during World War II ²⁰ *1

Primary cardiospasm is the only psychosomatic disease that is comparatively frequent in children, even in infancy, and the testimony is almost universal that psychologic factors initiate the disease. In infants it often follows wearing or a transition from breast to bottle feeding ^{22–24}. In older children, it may follow resentment of a disliked food, fright following the ingestion of a food that caused disagreeable sensations, a fright of any sort, or the insistent demands of a tyrunmical mother ²². The children are usually spoiled, tyrunmical, neurotic, and often suffer from enuresis and pavor nocturnus ²⁹. These observers all testify that the children can be cured by suggestive therapy or proper training of the parents

The comparative frequency of this psychosomatic disorder in children is in all likelihood due to the fact that their motivation is more largely governed by oral receptivity than in adults Apparently, cardiospasm represents an exaggerated and continuous form of such common emo-

tional symptoms as "difficulty in swallowing," "the food sticking in the gullet," and "lump in the throat," and, in the term of Hurst, an "achalsia," that is, the failure of the normal opening of the cardiac sphincter in the process of swallowing ²⁵ All evidence indicates that the changes in the sympathetic ganglia in the wall of the esophagus are secondary to the inflammatory process consequent to the prolonged stagnation of food content and are not primary

We do not regard the cardiospasm that is associated with ulcer as different from the primary variety. If the patient is questioned, one invariably finds that the cardiospasm is consequent to fear that the ingestion of food will cause pain or distress.

Our limited experience in attempting to evolve a characteristic type of personality in cardiospasm has afforded us the impression that these patients conform more or less to a mild form of the Graves' syndrome type

In this review of the personality types, it is apparent that there is more or less overlapping This could have been forecast readily when one considers that human behavior and motivation do not differ qualitatively, but quantitatively As a confirmation of this point of view, Hackfield found that by the objective interpretation of the Rorschach test, the psychologic-biologic structure of Graves' syndrome, gastrointestinal dys-function, mucous "colitis," and essential hypertension are identical 28 It is the dominance of certain attitudes that distinguishes not only the predisposition to these psychosomatic disorders but the temperament of peoples and races this sense the terms "normal" and "abnormal" possess only an arbitrary definition "Normal" and "abnormal" do not represent mathematical quantities, but ranges, and to determine where one ends and the other begins is an impossible accomplishment The difficulty is further augmented, because these attributes of personality bring in various compensatory adjustments subscribe to Cannon's concept that emotional responses represent a homeostasis, in other words defense mechanisms against pain, hunger, fear, and rage

Although the different varieties of emotion, such as fear, anger, distrust, anxiety, rage, love, sorrow, and joy, usually create the same physiologic response in a given individual, either as flushing, pallor, increased sweating, tremor, a bowel evacuation, increased or decreased intravascular pressure or blood glucose, a rise or fall in the metabolic rate, or an increase or decrease in the gastric secretion, etc., we do not believe that the particular nature of the environmental insult is an important factor in producing the variety of psychosomatic disorder that will be evolved

The same emotional insult may produce dia metrically opposite effects in different individuals. Aether have we observed that the nature of the psychosomatic disorder depends upon whether the insult is sudden, prolonged or reiterated or whether it is entastroplue or of lesser magnitude. These environmental insults have this in common They all induce an insecurity either social economic, or of existence itself. As Stanley Cobb expresses it, "it is not the emotion but the manner in which it is experienced that determines the physiologic response." ""

We feel that certain personality traits are dominant or characteristic in the background of some of these diseases We refer to the mental progena in essential hypertension, extraordinary sensitivity in Graves' syndrome the aggressiveness in peptic ulcer, and the submissiveness in colonic disorders. This, however is not equivalent to saying that these attributes are the direct cause of the development of the psychosomatic disease merely because these maladies are so frequently associated It is essential in this respect to synthesize the various attributes, their mutual relations, and their potentialities for compensation and eventually to instigate the disorder which is finally set off by the environmental insult the production of psychosomatic disorders therefore one may construct the following biologic sequence Constitution times Psychologic Trauma gnes Hyperkinesis resulting in psychosomatic discase

The overlapping of personality which we have described accounts for the frequency of the association of psychosomatic disorders in the same individual Also our study will show other interesting quantitative and sequential relationships.

Association of Psychosomatic Disorders

Essential Hypertension and Graves' Syndrome — Of a total of 993 cases of both disorders essential hypertension and Graves' syndrome were assocuated in 17.2 per cent. Clinicians have long been aware that hypertension follows either long-con tinued or so-called "burnt-out" or "spent" cases of Graves' syndrome in which the basal metabolic rate has attained normal levels, although many of the other classic manifestations of the disease are still present. Our percentage of the association is less than some reported by others, Rohm and Barath found 35 per cent and Askey and Toland, 33 per cent. 21.29 The latter also noted that in 80 per cent the blood pressure was reduced after thyroidectomy and in 47 per cent it returned to normal We have observed that hypertension not only follows the fully matured disease but even follows the larval types or what one may term the constitutional background in which the basal metabolic rate is within the normal range

These types have been termed Basedowid, autonomic imbalance, formes frustes, and neurocliculatory asthenia. They largely represent the cases that Page calls 'dencophable hypertension' is It has been our privilege to have noted this transition in individuals whom we have observed over a prolonged period. At first the systolic pressure is at the upper limit of normal with a wide pulse pressure. Later, both the systolic and diastolic pressure rise and show a marked lability. Subsequently, these pressures become fixed, both systolic and diastolic pressures approach considerable heights and, finally, the classic manifestations of cardiovascular disease ensue.

On the other hand the superposition of a Graves' syndrome on a previously existing hypertension must be exceedingly rare, if it exists at all We have not observed such an instance in our soiles nor are we aware of any reported cases. When one psychosomatic malady almost invariably precedes another and only rarely reversely, it is safe to conclude that the association of the two is not due so much to the overlapping of personalities but to the creumstance that the first malady is an activating agent of the second whether by increasing the insecurity and anxiety, or whether through some other mechanism is speculative.

Rypertension and Peptic Ulcer—Of a total of 822 cases of both diseases, these two maladies were associated in 89 per cent. It is difficult in the conventional hospital history to determine the duration of an existing hypertension, but in our series the procedence (when sufficient data are offered) of hypertension to ulcer and vice versa mas almost equal. One would infer that the per sonalities of both essential hypertension and peptic ulcer overlap considerably. Certainly, inward aggression which we deem an important component is common in both.

Graves' Syndrome and Peptic Ulcer -Of a total of 577 cases of both disorders the association occurred in 64 per cent This comparatively high incidence of association is interesting in view of the fact that hypochlorhydna and achlorhydna in Graves' syndrome is exceedingly common, especially in the later phases *1 One would presume, therefore, that ulcer would precede the onset of the Graves' syndrome in most instances, and this, indeed, we found to be the case. Of 11 cases of this association in which the precedence of the malady could be determined with reasons ble accuracy, the Graves syndrome preceded the ulcer in only two In eight the peptic ulcer preceded the onset of the thyroid disease. In one, the association seemed to be almost simultaneous This marked inequality of incidence would again indicate that in most cases the ulcer acted as an activating agent

Graves' Syndrome and Disorders of the Colon -Of a total of 774 cases the association of these two disorders was 11 2 per cent It is of interest that of this total, 9 7 per cent were cases of mucous and spastic "colitis", while only 1 5 per cent were cases of ulcerative colitis In most of the latter, a history was obtainable that the mucous and spastic "colitis" preceded the onset of the nonspecific ulcerative colitis, sometimes by many years, indicating strongly that the ulcerative lesions are usually the late manifestation of the functional colonic disorders. That increased tone and peristals s of both small and large intestine are exceedingly common in Graves' syndrome is a well attested roentgenologic observation 3° Chinical observation also confirms the precedence of Graves' syndrome to colonic disorders and not vice versa. It is safe to conclude that the personality changes in Graves' syndrome may predispose to a colonic disorder and that the personality of the latter is entirely passive in the reverse direction When both occur together, they may be simultaneous reactions, so that in such instances there is an overlapping of personalities

Graves' Syndrome and Cardiospasm—No instance of this association was encountered, so that apparently the two personalities do not overlap

Peptic Ulcer and Colonic Disorders —Of a total of 603 cases the association of these two maladies occurred in 12 6 per cent. It is of particular significance that all these colonic disorders were represented in the form of spastic or mucous "colitis". Not a single instance of nonspecific ulcerative colitis was encountered. This may be interpreted in one of two ways.

1 The functional lesion had not fully matured, and a larger series or a more prolonged follow-up would have revealed one or more cases of an associated nonspecific ulcerative colitis. We cannot evaluate this possibility.

2 The personality changes in spastic and mucous "colitis" on the one hand, and those of nonspecific ulcerative colitis on the other, vary in intensity of expression.

We are inclined to take the latter view, since we have already observed that in the fully developed types of nonspecific ulcerative colitis, the personality type is the direct antithesis of that of the peptic ulcer. The peptic ulcer is the sadistic, aggressive, forceful, go-getting, all-or-nothing individual. In nonspecific ulcerative colitis, he is submissive, dependent, weak-willed, and a defeatist at heart. His aggresion does not lead to attempts to dominate a person or a situation as in peptic ulcer but is a dependent on a negativistic aggression.

We conclude, therefore, that while there is a certain overlapping between the personalities of

peptic ulcer and the minor forms of colonic disorders, there is a direct antithesis between the personalities of peptic ulcer and nonspecific ulcerative colitis

Peplic Ulcer and Cardiospasm —Of a total of 203 cases of peptic ulcer, cardiospasm occurred in 9 5 per cent. In every instance, the peptic ulcer preceded the cardiospasm by a number of years. On questioning, such patients admitted that the cardiospasm arose entirely from fear that the ingestion of food would cause distress. From this it is evident that the ulcer works as an activating agent. For this reason, as we remarked before, we do not regard primary and secondary cardiospasm as distinctive disease entities.

Cardiospasm with Hypertension—Of 42 cases of cardiospasm, an associated hypertension was present in one case, an incidence of 24 per cent. In this case, the hypertension occurred in an elderly individual and was of long standing, while the onset of the cardiospasm had occurred only five months previously. In this instance, the cardiospasm arose from influences entirely unconnected with his hypertension.

Cardiospasm and Graves' Syndrome—Of a total of 416 cases of both disorders, the association of the two maladies occurred in two instances, or approximately 0.5 per cent. In one case, the two disorders appeared almost simultaneously, in the second, the cardiospasm preceded the Graves' syndrome by seven years. The cases are too few to permit any deduction.

Cardiospasm and Colonic Disorders — There was not a single association in our collected series

Summary

A study was made to note the frequency of association of psychosomatic disorders in the same individual. The following psychosomatic disorders were selected essential hypertension, Graves' syndrome, peptic ulcer, colonic disorders, including mucous "colitis," spastic "colitis" and nonspecific ulcerative colitis, and cardiospasm

We submitted the thesis that in the production of psychosomatic disorders the following biologic sequence may be constructed

Constitution times psychologic trauma gives hyperkinesis which results in psychosomatic dis-

We believe that the variety of psychosomatic disease which will be engendered is related to the type personality and not to the specific kind of psychologic trauma

The type personality coincident with these various psychosomatic diseases is described. In the description of these types a considerable overlapping is noted, accounting for the association of certain psychosomatic disorders in the same indi-

vidual. This accounts for the not infrequent association of hypertension and peptic ulcer, and Graves' syndrome and colonic disorders On the other hand, the invariable precedence of one psychosomatic disorder to the other is a strong indication that the first disorder acts as an activating agent This applies to the sequential rela tion of essential hypertension to Graves' syndrome, of pentic ulcer to Graves syndrome, and of cardiospasm to peptic ulcer

No instance of the association of peptic ulcer and nonspecific ulcerative colitis was noted in our senes, and we believe this is due to the fact that the personalities of the two diseases are antithetic

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ULCER PATIENTS NEED REST

Complete physical rest for patients with stomach ulcers gots strong support from research by Dr C W Lillchei, National Cancer trainec and Dr O H. Wangensteer professor of surgery at the University of Minnesota Medical School at Minneapolis.

Moderately severe physical activity from fairly stremuous exercise they find helps bring on a certain type of ulcers in dogs.

The ulcers are the kind that come following injections of histamine a body chemical which stimulates stomach activity and dilutes

small blood vessels. Histamine provoked ulcers about three times as often in dogs tired by strenuous muscular activity as in dogs that were not doing tiring exercise, the scientusts report to the January Society for Experimental Biology and Medicine

Strangely however muscular fatigue decreased the output of hydrochloric acid in the dogs' stom achs. By decreasing the acid output, it might seem that muscular fatigue would decrease instead of increase ulcer formation. The apparent paradox, the scientists explain suggests that muscular fatigue affects the stomach lining itself and makes it more vulnerable to the action of the acid-pensin mixture in the stomach juices.

Strenuous muscular exercise probably affects the stomach lining by changing its blood circulation The exercise would cause blood to be diverted from

the stomach lining to the leg muscles.

Constricting the blood vessels, so that less blood gets to the stomach lining aids and abets ulcer for mation the scientists found in another experiment The blood vessel constriction in this case was brought about by injections of adrenalin. This fits in with the muscular fatigue findings because muscular fa tigue is known to cause liberation of adrenalin in the body

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THE ELECTROCARDIOGRAM IN INFECTIOUS MONONUCLEOSIS

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A NUMBER of years ago Master and Jaffe called attention to the transient, nonspecific changes that appear in the electrocardiogram during certain acute infections and vascular diseases ¹² Since that time similar electrocardiographic abnormalities have been reported in an ever-increasing number of infectious diseases. One of the latest of these is infectious mononucleosis, during which alterations in the T-waves and in the P-R interval have been observed ³⁻⁵ In a recent analysis of the electrocardiograms in a series of cases of acute infections, it was found that a relatively large percentage of patients with infectious mononucleosis had electrocardiographic abnormalities ⁶

The present report is a review of 22 cases of infectious mononucleosis in which electrocardiograms had been recorded. These cases were selected from a group of 50 consecutive patients with this disease, in the remaining cases no tracings had been made. The patients presented the various clinical symptoms and signs usually encountered in this disease. In all instances the diagnosis was confirmed by finding characteristic cells in the blood or the bone marrow, by a positive heterophil reaction, or by both

Electrocardiographic Findings

One of more electrocardiograms were taken in the 22 cases, employing the three standard limb leads and CF₄ or multiple CF leads. Significant deviations from normal were present in nine cases, or 41 per cent (Table 1). The tracings were normal in ten cases, minor changes within the normal range of variation occurred in three cases. In most of the cases in which the electrocardiograms were normal only one record was made. Serial tracings would probably have revealed abnormalities among this group

Lowering or inversion of the T-waves was the characteristic deviation in nine abnormal electrocardiograms. Two of these also showed changes in the P-R interval. In one instance the

P-R interval was prolonged to 0.24 second, in the other the P-R interval varied from 0.20 to 0.16 second in serial records, without appreciable alteration in the rate of the heart. Significant Q-waves, QRS abnormalities, or RS-T deviations were not found. In several of the electrocardiograms of the remainder of the group the RS-T segments were slightly elevated, but, as these deviations persisted, importance was not attached to them.

The T-wave alterations appeared in both the limb and the chest leads in three cases, in the chest leads alone in two cases, and in the limb leads alone in four cases. The degree of T-wave inversion was moderate in eight cases, in one, T₂ and T₃ became deeply inverted (Fig. 1)

Occasional auricular premature contractions occurred in one case Ventricular premature beats and other arrhythmias observed by several authors did not appear among our patients ⁵ ⁷

In the cases with abnormal electrocardiograms the deviations were noted in the initial tracing made within forty-eight hours following hospitalization. However, since the patients had been ill for days or weeks prior to admission, correlation with the day of onset of symptoms of infectious mononucleosis disclosed that the electrocardiogram may be abnormal as early as the fifth day of illness. In several instances the record returned to normal within ten days. Four patients exhibited the abnormalities for three to four weeks.

Clinical Correlation of the Electrocardiogram

We were unable to detect a correlation between the electrocardiographic deviations and the clinical and laboratory findings. Active carditis was not noted in any of the patients. A pericardial rub was not heard at any time. Soft systolic murmurs audible over the aortic area in two cases and over the apex in another were believed to be "functional" in origin. In one instance a

TABLE 1 -ECG FINDINGS IN INFECTIOUS MONOYUCLEOSIS (FIGS 1-6)

Саве	Sex	Age	T_1	T ₂	Т,	T ₄	P-R Interval
MV	M	15 28	Low	Inverted	Inverted	Tourneted	
D M M P	M	17	Low	Diphasic	Low	Inverted Semi inverted	
\$ D	ř.	$\frac{12}{4^{1/2}}$	<u>rom</u> Fom	Low Low	Inverted Semi inverted	Inverted Notched	
ĀK	M M	31 17	Low Low	Low Isoelectric	Diphasic		0 24 to 0 17 second
s B s F	F M	43 24		Low	Inverted	Diphasio	0 20 to 0 16 second

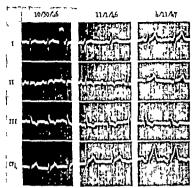


Fig 1 M V—October 30 1946 T, low T; diphasic T; inverted Aovember 1, 1946 T; now inverted April 1 1947 Normal ECG T; taller T; upright.

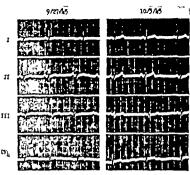
systolic murmur heard over both the apex and the base may have represented chrome rheu matic valvular disease although evidence of an active rheumatic condition was lacking

The highest temperature ranged between 102 and 104 F, the duration of fever being between five and thirty days. The leukocyte count varied from 3,800 to 20,900 the percentage of atypical lymphoid cells, from a few to 23 per cent. In two cases the heterophil reaction was only I. 8, in the others it was positive once reaching the very high titer of 1.32,768. Jaundice was present in one patient.

The chineal course in all instances was mild or moderately severe. The patient whose electrocardiogram showed the most pronounced inversion of the T-waves ran a very benign course.



Fra 2 J P —October 2 1945 T, diphasic October 20 1945 T, lower T, inverted April 8 1947 Normal ECG T, taller T, upright.

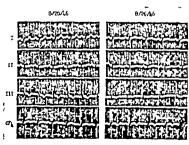


F10 3 D M —September 27, 1045 T₁ low T₂ diphasic, T₄ low, T₄ conn-inverted October 3 1945 Normal ECG T_{1-2, 4} taller T₄ upright

Comment

As with other acute infectious diseases, non-specific alterations may occur in the electrocardingm of patients with infectious mononucleous. Abnormalities have been observed most frequently in the T waves—Occasionally, there is disturbance in auriculovontricular conduction and depression of the RS-T segment as well as minor arrhythmias. These observations again illustrate the futility of attempting to make an etiologic diagnosis as for instance rheumatic fever solely on the basis of such nonspecific changes in the electrocardiogram.

Longcope included in his series of cases of infectious mononucleosis a patient whose electrocardiogram showed ventricular premature contractions and 'T inverted [†] The lead in which the T wave was inverted was not inentioned Logue and Hanson in an article on partial heart block listed one case of infectious mononucleosis.



Fro 4 M P—August 20 1946 T₁ low T₄ inverted T₄ low August 26 1946 T₁ lower T₂ low T₄ less inverted T₄ inverted

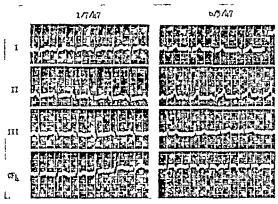


Fig 5 S D — January 7, 1947 T₁ 2 low, T semi-inverted, T₄ notched, June 3, 1947 Norma ECG, T₁ 2 taller, T₄ inverted

with a prolonged P-R interval 8 Candel and Wheelock presented eleven cases of acute infections with electrocardiographic changes 9 Among these was a case of infectious mononucleosis with minor T-wave alterations in the chest lead Evans and Gray biel reported four cases of infectious mononucleosis with T-wave changes consisting primarily of lowering of the T-waves and, in one instance, inversion of T, 4 These abnormalities persisted from six to forty-one days The authors considered the T-wave changes, at least in their first case, to be the result of pericardial involvement, because they persisted "over a longer period of time than would be expected if the myocardium alone were affected "Young included two patients with infectious mononucleosis in a series of 13 cases of upper respiratory infections in which electrocardiographic changes occurred 10 In one case the P-R interval varied between 0 16 and 0 20 seconds, and in the other the T-waves varied in height

Wechsler, Rosenblum, and Sills compiled the largest group of abnormal electrocardiograms in this disease during an epidemic at an Army post ⁵ Of 223 patients, 45 cases showed T-wave changes, and 14 showed prolonged P-R interval with or without T-wave alteration—The largest P-R interval noted was 0.40 second—There were two instances of transient second degree heart block

In a wide variety of bacterial, parasitic, and virus diseases electrocardiographic changes can be correlated with the findings of acute myocarditis anatomically, even though clinical signs and symptoms are frequently absent or minimal ⁶ In infectious mononucleosis, as in upper respiratory infections in general, the interpretation of the T-wave changes is rendered difficult by the benign course of the disease, the absence of cardiac signs, and the paucity of postmortem material

Recent reviews of many hundreds of cases of

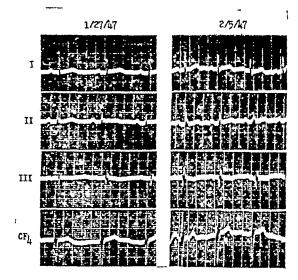


Fig 6 P L—January 27, 1947 T, low, T-low, P-R interval 0 24 second, February 5, 1947 T₁ 2 taller, P-R interval 0 18 second

infectious mononucleosis report that cardiac symptoms were not found in any patient 11-17 However, Wintrobe mentions a patient in whom "tachycardia and cyanosis became so pronounced as to suggest acute cardiac dilatation "18 Bradshaw reports a case in which signs of mitral stenosis and congestive heart failure developed six weeks following recovery from infectious mononucleosis 19 However, the sequence of events in this case is open to question. In one of the cases of Evans and Graybiel a pericardial friction rub was heard, and in another there was slight cardiac enlargement which subsequently disappeared In a fifth case, not included in their group of patients with abnormal electrocardiograms, pericarditis with effusion developed without evidence of rheumatic fever. In the large series of Wechsler, Rosenblum, and Sills, an occasional patient complained of intermittent, sharp. precordial pain 5 Except for a greater tendency to relapse, there were no other significant differences between those with abnormal and normal electrocardiograms Only one instance of unexplained cardiac enlargement was noted authors also found that, following defervescence, bradycardia and sinus arrhythmia obtained for at least as long as the electrocardiograms were abnormal This, together with a peculiar waxing and waning of T₁ for sixth months or more, led these authors to consider the underlying mechan-15m to be either autonomic imbalance or possible myocardial involvement

Only recently has autopsy evidence of the existence of myocarditis in infectious mononucleosis been made available. Ziegler describes the case of a twenty-two-year-old girl whose "heart muscle appeared remarkably free of collular infiltrations It showed the neute changes com mon to many infectious diseases"29 Allen and Kellner report the necropsy findings in a twenty three-year-old soldier who was killed accidentally two weeks following cossation of symptoms of in fectious mononucleosis 21 The patient had been only moderately ill, and clinical signs of cardiac involvement had been absent Focal interstitial infiltrations composed of mononuclear cells and lymphocytes were found. The collections of cells were small to moderate in size. There was no muscle atrophy or replacement of muscle fibers In two fatal cases of infectious mononucleosis with involvement of the central nervous system and the Guillain-Barré syndrome the hearts were essentially normal except for scattered subepicardial petochiae, indistinct cross strictions, and occasional, small, perivascular collections of lymphocytes in the epicardium of the left ventracle.22 Brien mentions two fatal cases in which there were present "small accumulations of mononucleosis cells in the muscle and under the endocardium."23 Very recently Gore and Saphir listed nine intal cases, six of which showed myocarditas histologically 24

It has been suggested that infectious mononucleosis is a virus diseaso, but this is still uncertain It is known that my ocarditis may develop not only during the course of bacterial infections but also during such virus diseases as influenza A, poliomyelitis and mumps 25-27 Myocardial anovemia may play a role in the development of the Virus pericarditis has also been delesions 24 ecribed **

Since it is evident that true myocarditis may occur in infectious mononucleosis electrocardiographic changes should not be disregarded or conndered lightly Despite the absence of climcal signs and symptoms referable to the heart, the high proportion of abnormal electrocardiograms that occurred in our group of cases indicates that it is advisable to take tracings routinely. If abnormalities are found the patient's activities should be restricted, and the period of convalescence should be extended until the record returns to normal or remains stationary in the unusual cases in which the changes persist

Proper evaluation of the T wave changes is important. In some of the cases mentioned in the literature slight lowering of the T-wave in one lead is the only deviation reported 10 In view of the fact that minor alterations in the Twave may be caused by such factors as fever in creased tonus of the autonomic nervous system tachycardia, acid base disturbances and the position of the patient, only well-defined alterations

should be considered indicative of myocardial involvement

Summary

Pronounced deviations in the T wave were present in nine of 22 cases (41 per cent) of infectious mononucleosis In addition to the T-wave changes, the P R interval was prolonged in two of the cases

These changes were probably the result of organic changes in the myocardium although clini cal signs of acute myocarditis rarely occur in infectious mononucleosis

Whenever possible, an electrocardiogram should be recorded routinely in this disease. When abnormalities are present the period of convolescence should be extended until the tracings become normal

The electrocardiographic alterations in infections mononucleosis are nonspecific and similar to those that occur in numerous other acute in fectious diseases

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THE NITROFURANS

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POLLOWING the discovery of the sulfonamides, a marked stimulation in basic research to find other effective chemotherapeutic In 1944, Dodd and Stillagents became evident man, reviewing the literature, noted that several investigators had found the furan group of compounds to be bacteriostatic 1 Following this lead, they prepared 42 furan compounds and screened them against Staphylococcus aureus, Streptococcus hemolyticus (S pyogenes), Diplococcus pneumoniae Type 1, Eberthella typhosa, Escherichia coli, and Pseudomonas aeruginosa (P pyocyanea) They found the nitio group was essential in activating these furan compounds to produce effective bacteriostasis They also noted that some of the nitrofurans were bactericidal as well as bacteriostatic, this fact being determined by the concentration of the drug compounds that were selected from the initial 42 were definitely bacteriostatic against at least five of the six test organisms which included both gram-positive and gram-negative bacteria

Cramer and Dodd investigated the mode of action of the nitrofurans using Staphylococcus aureus as the test organism 2 They selected the six most promising compounds from the Dodd-Stillman investigation Of these six, one compound, nitrofurazone NNR, 5-mitro-2-furaldehyde semicarbazone (Furacin), was found to have an unusual mode of bacteriostatic action showed marked activity during the lag phase of growth, prolonging the time of the phase ing this lag phase no reproduction takes place. and it is thought to be normally a period of intense vital activity of the organism. At this time it was not known whether Furacin affected any vital process other than reproduction so that the time of maturation was prolonged, or whether it interfered directly with cell division

A more recent publication by Cramer discusses the mode of action of Furacin on bacteria ³ This is a very technical article based on the application of physiochemical methods to the study of the action of Furacin against Staphylococcus aureus He concludes that a chemical reaction takes place, during which Furacin is reduced. As a result of this reduction, the enzyme system necessary to the growth of the bacterium is temporarily mactivated, and thus, the so-called "lag phase" of the organism is prolonged. This results in a

Presented at the 41st Annual Meeting of the Sixth District Branch of the Medical Society of the State of New York Norwich New York October 15, 1947 period of relative inactivity in the life cycle of the organism

It may be inferred from the above that during the so-called "lag phase" the normal antibacterial mechanisms of the host could take over and eliminate the invading organisms

Furacin is a lemon-yellow, crystalline substance. It is stable at 15 pounds pressure for at least fifteen minutes in the autoclave but decomposes above a temperature of 227 C. It is slightly soluble in water (1 4,200) and soluble in Carbowax (polyethylene glycol, 1 100). Upon exposure to light and certain metals it is discolored but still retains its antibacterial efficiency.

In 1945, Krantz and Evans investigated Furacin pharmacologically ' They found the drug to have no toxic effect on blood pressure, respiration, or cardiac action when administered to dogs in relatively large doses In vitro tests indicated no effect on the cytochrome ovidase system ever, there was definite retardation of tissue dehydrogenase activity by the drug in vitro In acute toxicity tests the LD to for rate was found to be 590 mg per Kg, and 380 mg per Kg for mice Chronic toxicity tests in monkeys, who received orally 0 3 Gm daily for five weeks, produced no significant pathologic effects. In rats, 04 per cent Furacin in the diet caused death tologic sections showed coagulated albuminous fluid in kidney tubules and small focal necrotic areas in the livers

After the animal experiments, these investigators ran several preliminary tests in man. One of them (Evans) took 100 mg of the drug orally with no demonstrable symptoms. One hundred mg were then given to each of several other persons three times a day. Finally the dose was increased to 3 or 4 Gm daily. This dose was well tolerated in 80 per cent of the test subjects. Twenty per cent, however, experienced natisea. Results of routine blood and urine tests were normal.

The conclusions drawn from this pharmacologic study were that relatively large doses were non-touc to animals. Toxic doses in animals produced hyperexcitability of the central nervous system. Preliminary oral ingestion of the drug by man seemed to indicate low toxicity. The animal work has continued under Carr, and preliminary reports indicate that 0.1 Gm a day has been ingested by dogs and monkeys for a period of over five months with no evidence of toxicity.

In 1946, Dodd investigated the chemothera-

pautic properties of Furacin in vitro and in vivo and found definite beneficial effects in the treatment of both bacterial and trypanosomal systemic infections in mice by oral, subcutaneous, or intramuscular administration of the drug. He showed in vitro that the drug had a wide antibacterial spectrum against many gram positive and gram-negative organisms. He also noted that, while the nitro group conferred antibacterial activity in vitro, the only compounds effective in vivo were those nitrofurans closely related to the semicarbazone compounds

Dodd confirmed Krants and Evans' findings that the toxic doses in rats and mice produced hyperirritability, tremors, convulsions, and respiratory failure, indicating a toxic effect on the central nervous system He found the LD in mice to be 545 to 587 mg per Kg Histologic studies showed no pathologic changes to account for the symptoms produced by oral administra tion but severe toxic hepatitis and extensive degeneration of the renal tubules were found after massive subcutaneous doses The in vivo studies indicated that Furacin was effective orally in mice infected with Staphylococcus aureus Streptococcus pyogenes (hemolytic) Salmonella schottmuellen and Salmonella aertrycke It was not effective against the pneumococcus verity of the infection had a definite effect on the survivals especially in the gram-negative species It was very effective in the treatment of Try panosoma equiperdum infections protecting 100 per cent of the rats against a 100 per cent fatal dose of organisms when 100 mg per Kg of the drug was administered orally

Preliminary experiments indicated activity against Treponema pallidum in vitro and in vivo in infected rabbits. This preliminary work has been confirmed recently by another investigator and the work is being continued to ascertain whether or not permanent clinical and serologic

cure is possible?

A recent report by Green and Mudd indicates that when several gram positive and gram-nega tive bacteria (Staphylococcus aureus Escherichia coli, Protous vulgaris, Streptococcus viridans Staphylococcus albus and Shigella paradysen teriae) were made resistant by repeated cultures in increasing concentrations of three other drugs 1.e., sulfathiazole streptomycin and penicillin or obtained from patients being treated with these drugs, they were still as susceptible to Furacin as the original nonresistant organisms. In other words no cross resistance to Furnem develops in vitro as the result of repeated exposures of the selected organisms to sulfathuzole streptomycin and penicillin The advantage of this factor is obvious

In July of 1946 Dodd Hartmann and Ward

reported on the effects of several nitrofurans on the healing time of experimental wounds in rabbits. They concluded that two of these compounds were nontritating, nontone, and had no adverse effects on healing. One of these compounds was Furacin.

Neter and Lamberti in August of 1946 reported that Furacin had proved effective in the treatment of infected wounds in rabbits ¹⁰ These wounds were artificially made and infected with beta hemolytic streptococcus. They concluded that further clinical work was definitely indicated

The discussion so far has dealt with the original chemistry pharmacology and bacteriologic work with the compound. A review of the literature covering the use of Furacin in the chinic is now in order.

Clinical Use of Furacin

The first clinical results reported were by Snyder Kiehn and Christopherson on chromically infected war wounds in November, 1045 ii. They made cultures from the wounds and determined the bacterial flora and also checked the effectiveness of Furacin against the bacteria present in the wounds by cultures on blood agar. The wounds were treated by application of Furacin Soluble Dressing. They were redressed and subsequent cultures usually taken each day thereafter. The series was small, consisting of ten patients. However, it was very well controlled.

Snyder and his coworkers noted that clinical improvement in all cases was directly correlated with a quantitative and qualitative reduction in the bacterial flora, especially of gram positive organisms as demonstrated by repeated cultures in They concluded that the compound was highly effective in vivo in the control of surface infec-

The next report of interest was by Melenev and his coworkers in January 1946. They were particularly interested in finding antibacterial agents effective against gram-negative organisms not susceptible to penicillin Only five compounds met their stringent requirements. One of these was streptomy cin, and another was Furacin. They found that Furacin was effective against many of the gram-negative organisms, with the exception of Pseudomonas aeruginosa (P pyocyapea).

The next clinical investigation was by McCollough and summarized his findings in the treatment of infected war wounds ¹² He treated 94 chronically infected wounds 37 cases were healed completely and 45 cases showed improvement

Daily cultures were made and it was noted that Staphylococcus aureus and Streptococcus pyogenes usually disappeared shortly after therany was instituted. The gram-negative organisms were present longer than the gram-positive organisms despite the fact that the wounds were obviously healing A total of 597 cultures was made, and 97 of these were negative immediately after treatment was instituted Twelve of the wounds had been indolent with no change in size or amount of drainage for an average of fifty They healed in an average of twenty-one days after Furacin therapy was begun were four cases of sensitivity to the drug evidenced by local vesicular eruption and erythema All cleared within one week after the drug was These four patients gave a posidiscontinued tive patch test to Furacin. This was the first clinical observation of sensitivity to Furacin

The first report in the field of dermatology was made by Downing, Hanson, and Lamb in February, 1947 14 Two hundred twelve patients were treated Melenev's classification was used in appraising the results. In the summary of Downing's paper, it was noted that the drug did not interfere with normal granulation and epithelization of infected ulcers. There was no clinical evidence of toxicity due to absorption of the drug even when used in large amounts over prolonged periods of time. This was further confirmed by necropsy of three of the patients who died from other causes two of diabetes and one of a cerebrovascular accident From the bacterial cultures it was evident that a large percentage of the infecting organisms, both grampositive and gram-negative, was controlled by the drue

Furacin was found effective in the treatment of cutaneous diseases due to lower organisms and also in infected ulcers. It showed excellent results in the superficial infections such as impetigo and ecthyma

A note of warning was sounded in respect to sensitization. At the same time it was noted that the sensitivity factor was less than that of the sulfonamides and penicillin when used locally. A recent communication by Downing to this author indicates a sensitization rate of approximately 4 per cent. This corresponds to the average incidence reported in the literature to date

Shipley and Dodd reported the clinical and bacteriologic results obtained in the treatment of 90 cases with superficial infections ¹⁵ The results in 26 cases were reported as brilliant, in 44 cases as good, the results in the remaining 20 cases were either questionable or negative. Attention was called to the fact that the use of Furacin was no substitute for surgical intervention when indicated. In six skin graft cases the graft was applied to the recipient area that had been treated with Furacin, and no attempt was made to remove the drug before the graft was applied.

The majority of the grafts were successful When deep-seated abscesses were incised and drained and then packed with the medication, healing time was shortened. The decrease in amount of discharge and odor was very noticeable.

Fifteen vascular ulcers of the leg responded rapidly in so far as the infection was concerned. They granulated well, and no retardation of epithelization was evident.

In several cases the dressing was used to pre-

vent an anticipated infection in surgical proce-Two patients had a Torek operation The scrotal-thigh incision was covered with the Furacin Soluble Dressing, and no slough or infection occurred Two patients had a Mikulicz colostomy through an inguinal incision wounds healed by early granulation despite the presence of fecal material. In treating these cases, three facts were particularly noted the effect on the base of the ulcers, the amount of discharge, and odor In the majority, the infection disappeared almost at once, leaving a clean granulating base with no retardation of epithelization The wound discharge decreased appreciably within twenty-four to forty-eight hours The odor decreased within twenty-four hours and was closely connected with diminution of bacterial Two cases of sensitivity were noted, one after forty-four days' treatment, the other after eight days A fine, red, papular rash developed The erythema disappeared within fortyeight hours after treatment was discontinued

The bacteriologic studies were quite complete, Proteus vulgaris, Pseudomonas aeiuginosa, Bacillus pyocyaneus, and Aerobacter aerogenes were the most common gram-negative organisms Sixty-three per cent of the cultures became negative during the treatment in times varying from twenty-four hours to thirty days Resistance of the gram-negative species was greater than the gram-positive group The occurrence of the various organisms is shown in Table 1

Clinical and in vitro results with Pseudomonas aeruginosa (Bacillus pyocyaneus) showed the organism to be definitely susceptible to Furacin This finding was not in agreement with previous

TABLE 1 -INCIDENCE OF ORGANISMS

TABLE 1 INCIDENCE OF URGANISMS					
Organism	Percentage of Incidence in Cases Treated				
Gram negative Proteus vulgaris Bacillus pycoyaneus Escherichia coli Aerobacter aerogenes Gram positive	40 87 5 33 5 25				
Diphtheroids Staphylococcus albus Streptococcus pyogenes	37 5 12 5				
(hemolytic) Stsphylococcus aureus Streptococcus anhemolyticus	7 1 6 6 0				

reports. The possibility of symbiosis being re-

sponsible was considered

A recent publication by Robinson and Robin son confirms the effectiveness of Furacin in the field of dermatology 18 They treated 171 pa tients with the following drugs incorporated in cintments penicullin, tyrothricin, Furacin am moniated mercury, and boric acid Occlusive dressings were applied daily under direct super vision to 50 patients, with daily cultures being made of the lesions It was found that Staphylococcus albus and S aureus, and Streptococcus pyogenes (hemolytic) were the most common causative organisms. The remaining 121 pa tients used the medication themselves at home and were checked at weekly intervals Ecthyma and impetigo contagiosa comprised 167 of the cases. Satisfactory results were obtained with all the preparations used and varied only in length of time necessary for healing. They noted that the applications of penicilin and Fura cin outments caused healing in somewhat fewer average days than the other agents Reactions due to sensitivity were noted in three of 17 pa tients using tyrothricin, with ammoniated mer cury in one out of 68, with Furacin in two out of 37, with penicillin in one out of 29 and with borie acid in none of 20 patients

Miller and his coworkers have recently reported good results with Furacin Soluble Dressing in 16 of 18 cases of impetigo with times of cure aver

aging eight days 17

This summarizes the publications on Furacin to date A discussion of reports on the present use and results in the various specialities is now in order

Specialty Uses of Furacin

Surgery — Many new uses of Furaem have been reported in the surgeal specialties. In thoracoplasty for pulmonary tuberculous the operative wound and occasional resulting sinus are being packed with Furaem impregnated gauge. The pack is replaced frequently and granulation and healing times of these types of wounds have been significantly shorter than the controls. Also, in the field of thoracic surgery injections of 50 to 100 cc of Furaem Solution into the pleural cavity in secondarily infected tuberculous empyremas have greatly facilitated subsequent closed drainage of the cavities.

In plastic surgery it is routine to prepare the recipient site with Furacin dressings and in many cases the graft is applied without removing the remaining Furacin ¹⁶ It is also routine to treat the donor site prophylactically. In a series of over 100 cases use of Furacin Soluble Dressing has cut down the time necessary to prepare the infected recipient site from a previous average of

seventeen to twenty three days to nine to thirteen days in most cases This is approximately a 40 per cent decrease in the time required

Proceedings —Furnam Soluble Dressing is being used preoperatively in pilonidal cysts and before hemorrhoidectomy to decrease infection. It is also used routinely as postoperative treatment in these cases and in rectal fistulas. A suppository is now being prepared to handle this problem more effectively.

Gynecology and Obstetrics—Furacin Soluble Dressing is being used on vaginal tampons for the local treatment of cervicitis following cauterization, and after operative repairs ¹¹ A vaginal suppository and cream containing Furacin are now being evaluated in the clinic to determine if they are more satisfactory than the tampon method of application.

Urology —Instillation of Furnein Solution in cystitis either full strength or diluted with sterile distilled water, has been reported to be effective "

Orthopedica — Use of Furacin Soluble Dressing as a packing in osteomyelitis has been reported, but results are controversial and more work is necessary before any conclusions can be reached

Otology —Funcin Solution has been used rather extensively in the treatment of otitis externa and otitis media is One series was conducted at a training school for mentally deficient children. The medical staff had had great difficulty with chronic otitis media in these children. The condition had been present for years in some of the patients. Over a period of six months 10 patients were treated of which 17 had a true otitis media with a perforated membrane and discharge. Two others had an external otitis. The age of the patients wanted from eight to twenty one years.

The results were as follows three of the pa tients were markedly improved with no drainage for three four, and five months, respectively The other 16 had symptomatic relief, i.e., decrease in amount of discharge and cessation of foul odor In the three cases that were markedly improved, one had a staphylococcic infection in another there was no culture obtainable, and in the third Proteus organisms were isolated In the first two cases the ears were dry In the third moisture was still present behind the tympanic membrane Of the total of 19 patients, one showed a local sensitivity to the drug, manifested by a weeping, red, swollen external canal This is in agreement with the general consensus of opinion that approximately 4 per cent of patients will be sensitized to Furncin used over prolonged periods

There have been other favorable reports from otologists. One physician has used it in several cases of otitis externa and otitis media with good results. He recently had a case of otitis externa

due to Pseudomonas aeruginosa (B pyocyaneus) which responded very satisfactorily A number of other preparations had been tried on this patient without effect Another report indicates it to be fairly effective in the treatment of Proteus Furacin Soluble Dressing has been used with some success in chronically discharging mastoidectomy cases In another series of 12 cases of otitis treated with Furacin, good results were obtained in ten cases The bacterial flora were mostly Proteus, Pseudomonas, and Diphtheroids, and two of the cases treated were heavily infected with hemolytic Staphylococcus albus

Rhinology —Furacin Solution has been used to treat an extensive osteomyelitis involving the hard palate, the lateral and posterior wall of the antrums, and the turbinate bones, following a septal operation 18 Penicillin, sulfonamides, and tyrothricin were of no value Irrigation of the sinuses and subsequent instillation of Furacin Solution every three hours caused a prompt fall in the temperature and greatly lessened the discharge and eliminated the foul odor case the symptoms were due largely to Proteus, although cultures showed Staphylococcus, Streptococcus, and Proteus Furacin Soluble Dressing has also been used in packing an open osteomyelitis of the frontal sinus

Ophthalmology—Furacin Soluble Dressing is being used in the treatment of corneal burns It has also been used for conjunctivitis and blepharitis of bacterial origin and following drainage of infected meibomian glands When the drug is used around the eye, the possibility of sensitization after prolonged use should be boine in mind

Systemic Use of Furacin —Furacin was administered orally to 84 patients by Shipley and Dodd to determine tolerance, dosage, and therapeutic effectiveness 20 The dosage varied from 1 to 6 Nausea with occasional vomiting was the most common untoward reaction sitization and peripheral neuritis occurred in one Routine laboratory studies were nor-Excellent results were obtained in two mal cases of acute typhoid fever, also, seven cases of cystitis and three of pyelitis all infected with Escherichia coli showed remarkable improvement Five of seven cases of gonorrheal salpingitis re-The two cases sponded rapidly to treatment which did not respond showed large pelvic abscesses when a laparotomy was performed review of these cases, it was noted that the gramnegative organisms, especially Escherichia coli and Eberthella typhosa, are particularly sensitive It also appears that the drug is most effective in infections involving the gastrointestinal and genitourinary tracts The results warrant further clinical evaluation

Future Possibilities

It was previously mentioned that Furacin was active against the organism Trypanosoma equip-Sleeping sickness is caused by an organism of this group. The problem is now being thoroughly investigated at the University of Texas where facilities are available for intensive study of this organism Also, the possibility that the drug may be active against the Mycobacterrum tuberculosis, either alone or in conjunction with streptomycin, is to be investigated by the laboratory at the Trudeau Foundation

This paper has dealt primarily with Furacin (5-nitro-2-furaldehyde semicarbazone) ran series contains many other compounds besides Several of these compounds synthesized recently have given evidence of pharmacologic activity, and one has shown a pronounced antihistaminic effect with a smaller dosage and lower toxicity than any other drugs of this type now available Another compound exhibits definite sympathomimetic effects

These compounds have been mentioned to indicate the varied potential therapeutic value that may be hidden in the furan group of compounds which seem to have been neglected in the frantic search for newer and better chemotherapeutic agents

Summary

This paper summarizes the history of the nitro-It touches briefly on their chemistry. pharmacology, and bacteriology

The significant results of clinical investigations, as reported to date, are discussed mention is made of future possibilities of furans

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COCCIDIOIDOMYCOSIS IN VETERANS OF WORLD WAR II

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HUMAN infection with the fungus Coccidioldes immits occurs in the United States principally in endemic areas in southern Call forms, western Texas, Arizona New Mexico and probably also in southern Utah. These localities have been designated as true endemic areas because of the occurrence of outbreaks of this disease, the results of skin testing with cocculioidia, recovery of the fungus from the soil, or the presence of the infection in autopsied desort animals ¹²

Spondic cases have been reported from other sections of the country. Usually such cases have given a lustory of residence in one of the endemic areas. Occasionally it has been difficult to determine the mode of infection especially when the patient gave no history of travel in an endemic region. In such cases infection has been assumed to occur by unusual means.

As a result of World War II, however coccidodal infection can no longer be considered a disease confined to the southwestern or western United States. Increase in travel facilities shifting populations, and exposure of soldiers in training areas in the endemic belt have resulted in the discovery of cases of coccidioidomycosis far from their original geographic site of infection

Two such cases are herein presented in which the primary infection occurred while in Army service in an endemic area. The diagnosis of cocadioidomy cosis was not made for some time however, after their return to civilian activities in New York City

Case Reports

Case 1—(Residual pulmonary coccidioidal infil-tration resembling tuberculosis.) The patient was a woman who was discharged from the Army in Janu ary 1946 In January 1947 a routine chest x-ray was taken as part of a chest survey of Hunter College students. The roentgenogram revealed an infiltra The patient was referred to a tion in the left lung Health Department clinic where the findings were confirmed and she was advised to enter a tubercu losis sanatorium. She was subsequently examined at the New York Regional Office of the Veterans Administration The patient volunteered the in formation that she was a positive reactor to coccidioldin and suggested that her pulmonary infiltra tion might be due to coccidendomycosis. Further questioning elicited the following information

While in the Army sho had been stationed in the desert 30 miles north of Tueson, Arizona, from May 1943 to February, 1945 Routine coccidioidin skin tests were done on all personnel at periodic intervals.

She was found to have a positive skin test after six months in the endemic area, but no cheet film was taken. She gave no history of respiratory infection at any time during her Army service.

Because of this additional history further studies were made. Tuberculin skin tests with 0.1 mg, and 1 mg, were negative. A coccidioidm skin test in dilution of 1.1000 was strongly positive after twenty-four hours. An x-ray taken May 15.1047 showed a nodular infiltration in the peripheral portion of the left infraclavicular region. The nodule measured 1.5 cm in diameter (Fig. 1). A simi-



Fig. 1 \ ray taken May 15, 1947, showing nodular infiltration in the peripheral portion of the left infraclavicular region

lar rounded density was seen in the soft tassue of the base of the neck on the left side having the appear ance of a cervical gland Reinspection of the chest x ray at separation from the Army taken January 18 1946 revealed the identical infiltration in the left lung field The induction x ray taken March 11 1943 showed no evidence of pulmonary disease.

This patient evidently received her primary coccidioidal infection while in the Arizona desert as shown by the positive reaction to coccidioidin after six months residence in that region. The nodular infiltrate in the left lung represented an inactive residual lesion of pulmonary coccidioidomycosis. The negative tuberculin tests aided in differentiating the pulmonary infiltration from tuberculosis.

Case 8—(Disseminated coeridioidomy cosis with pulmonary and skin manifestations.) The patient was a man who had been in the Army in the Cali fornin Arizona desert maneuver area for several months in the spring of 1944 In 1945 about ten months after leaving this region he developed a skin cruption on the left postenor chest wall with the formation of pink, crythematous, granulomatous plaques. A diagnosis was made of lichen planus.

He was hospitalized in November, 1945, at an Army hospital. A routine chest \ray revealed infiltrations in both lungs. He was discharged from the service in November, 1945, with the following diagnosis. Lichen planus, chronic, annular, hypertrophic, and tuberculosis, pulmonary, reinfection type, arrested.

After return to civilian life, he was treated by a private physician for the skin lesions on the posterior chest wall with ultraviolet therapy and injections of bismuth subsalicylate. He was subsequently seen at the New York Regional Office of the Veterans Administration in April, 1947, when he complained of bloody expectoration. Physical examination of the chest was negative. A chest x-ray revealed a nodular and patchy infiltration involving both apices and infraclavicular regions (rig. 2). A diagnosis

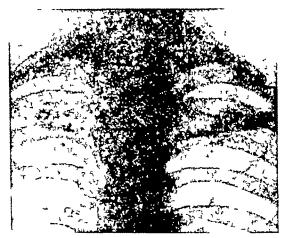


Fig 2 X-ray taken April 3, 1947, showing patchy and nodular infiltration of both upper lung fields

was made of chronic pulmonary tuberculosis, reinfection type Wassermann and Kahn tests were negative

Because of the failure of the skin lesions to respond to therapy, a skin biopsy was done April 30, 1947, and revealed typical findings of coccidioidal granuloma. This was further confirmed by a skin scraping which demonstrated numerous spherules in the wet preparation. Tuberculin skin tests were positive. Coccidioidin skin tests were negative. Reinspection of the chest x-ray taken November 14, 1945, at the time of discharge from the Army, revealed the identical pulmonary infiltrations seen on later films.

This patient undoubtedly received his coccidioidal infection while in the California-Arizona desert Dissemination occurred within ten months, a usual sequence of events. The pulmonary infiltration resembled tuberculosis. The negative skin tests to coccidioidin indicated the development of anergy Notwithstanding the grave prognosis usually attached to coccidioidal dissemination, this patient appeared in good health and showed no other evidence of coccidioidal granuloma.

Discussion

Residual lesions following primary coccidioidal

pneumonia may persist for years These lesions may frequently resemble pulmonary tuberculosis, as well as other pulmonary diseases ⁵

A history of pneumonia or "grippe" following exposure in an endemic region in a positive coccidioidin reactor is of aid in the diagnosis of coccidioidal disease However, many infections take place without manifest clinical disease such instances, the differential diagnosis of a pulmonary infiltration may be quite difficult, particularly if the individual reacts to both coccidioidın and tuberculin When this occurs, the diagnosis may be established only by periodic x-ray examinations of the parenchymal lesion 6 Precipitin and complement fixation tests are usually negative in cases of residual nodular infiltrates but may be of diagnostic value when pulmonary cavitation is present

Dissemination usually occurs shortly after the primary infection but sometimes does not appear until years later. The coccidioidin skin test is frequently negative after dissemination due to development of anergy. Diagnosis is established by the recovery of the spherules on biopsy, from sputum, or from draining sinuses. Serologic tests are usually positive.

No treatment is indicated for the residual pulmonary infiltrate, but periodic x-ray examinations should be carried out, since cavitation may occur in the nodular type of coccidioidal lesion

Treatment of coccidioidal granuloma has been disappointing and is conspicuous only by the large number of agents used without effect. Jacobson, however, has reported regression of isolated skin coccidioidomycosis by use of coccidioidal vaccine.

It has been estimated that this disease has occurred in approximately 6,000 members of the armed forces in clinically recognizable form and probably in a far greater number as subclinical infection. Furthermore, disseminated coccidio-idomycosis may continue to occur among these individuals for many years. Undoubtedly a percentage of these will be in the nature of wide-spread dissemination of coccidioidal lesions, and the mortality may be considerable. This is a problem for the medical profession as a whole, since the men who have been exposed to Coccidioides immitis infection will be scattered throughout the country.

Conclusion

- 1 Two cases of coccidioidomycosis occurring in former army personnel were found after return to civilian activities in New York City
- 2 These cases showed pulmonary infiltrations which were mistaken for tuberculosis
- 3 In cases of pulmonary disease, history taking should include the question of exposure in

the endemic area for coccidioidomycosis, especially in former army personnel

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FLOWERING GENTUS

The ingenuity of the country doctor is limitless He can perform miracles with the most primitive tools. There is the case of a country doctor who was called to see a patient fifteen miles away On arriving he found an elderly man suffering from a bladder ailment that required his being catheterized Unfortunately the doctor did not bring a catheter with

He stood looking through the window trying to think of a substitute for he did not relish the idea of making a thirty mile journey for the missing instrument. He did not pender long for he spotted some long stemmed dandelions growing in a near-by field. He procured one of the long stems and after soaking it in boric acid, used it as a catheter with great suc-OCAS.

FIRST PUBLIC HEALTH MENTAL CLINIC OPENED

The first U.S. Public Health Service demonstra tion mental health clinic has now been opened in Prince Georges County Maryland. The clinic will be operated jointly by the Maryland State Depart-ment of Health and the Public Health Service, with federal funds under the National Mental Health Act. Forty thousand dollars has been appropriated for the fiscal year 1948.

The clinic will be staffed by Public Health Service personnel Dr Mabel Rosa, child psychiatrist for merly with the Johns Hopkins Hospital will head

the clinic. Herbert Rooney formerly assistant chief of the Social Service Unit Boston Regional chief of the Social Service Unit Bosion Regional Office Veterans Administration, and Mrs Leonora Meister formerly with St. Elizabeth a Hospital, Washington, DC will serve as psychiatric social workers, Mrs. Adele Henderson, formerly with St. Louis Visiting Nurse Association, as public health nurse. A psychologist has not yet been appointed

Psychiatric service will be offered to all rendents of Prince Georges County Maryland which has a

population of 140 000

TASTIER FOOD IS PROMISE FOR HEART PATIENTS

The food of heart disease patients won t have to ose its savor because a Brooklyn scientist has applied to water in the human body the same chemical

trick that was used to desalt sea water

Dr I. J Greenblatt of Both-El Hospital Brook lyn, while serving in the Pacific area, realized that the principle of the ion-exchange desalting emergency hits of planes and lifeboats could be applied to heart cases characterized by droppy and swelling of the joints. He and M E Gilwood of the Permutt Company New York told the American Chemical Society meeting in Chicago that three tablespoons of a synthetic plastic swallowed after and before meals seem to allow such cardiac cases to eat a more nor mal diet.

Saltless tasteless diets largely of nee and starch have had to be the food of such heart cases doses of the new plastic, more normal food can be eaten as the material removes salt within the intestinal tract before it can get into the blood stream.

The ion exchange material used is a synthetic resin ground into tasteless powder grains coated with fatty chemicals and shellac .- Science A ews Letter May 1 1948

Case Reports

AN UNUSUAL CASE OF LEG EDEMA USE OF LATEX RUBBER BANDAGES

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EDEMA formation at times baffles both clinician and physiologist. The contributions of Landis, Drinker, and Warren and Stead have done much to rid edema of its mystery 1-3. Yet, one often encounters cases in which edema, the cause of which is difficult to perceive, plays a prominent role. That here reported affords an interesting problem in diagnosis and therapy of leg edema.

Case Report

M F, a white woman, aged 67, presented herself to the clinic complaining of excessive swelling of both legs. The illness dated back fifteen years when she noted gradual, painless, symmetric swelling of both legs. This swelling was restricted largely to the ankles and calves. Neither the feet nor the thighs were involved. She did not at any time have bouts of fever or glandular swelling. No history of thrombophlebitis, varicosities, cellulitis, or skin lesions of the legs could be cheited. She had never traveled out of the New England states. She had had no surgical operations. Invariably she was told that she had "clephantiasis" or "lymphedema," and that little could be done for her. Elastic bandages (Ace bandages) had been tried but could not be applied effectively on such enormous legs. Over the years the edema gradually increased until it was practically impossible for her to walk. At first she had noted that the edema tended to decrease with bed rest, but lately it had failed to do this.

bed rest, but lately it had failed to do this

Past History—In her forties she was extremely obese, weighing as much as 350 pounds. Dietary restriction in her early fifties gradually reduced the weight to approximately 250 pounds. She was told five years ago that she had high blood pressure. However, there were no hypertensive symptoms such as headaches or dizzy spells. Signs and symptoms of coronary artery disease or cardiac failure were also notably absent. Other than mild hay fever for the past six years, she had had no illnesses.

She had had two children, and no difficulties had been encountered during labor. The menopause came at age 52 and was without complications

came at age 52 and was without complications

Physical Examination—Height was 5 feet 7
inches, weight 287 pounds, blood pressure 230/120, pulse 68, respirations 18, temperature 98 8 F A slight stare was present, but there were no other suggestive eye findings, nor was the thyroid palpable. There was no enlargement of the salivary nor of the cervical lymph glands. The veins were not distended. The heart was regular in rhythm, and no murmurs were present. The aortic second sound was accentuated. The abdomen was soft and presented no organ edges or masses. Both legs were enormously swollen, especially at the ankles (Fig. 1). Here the circumference was 30 inches. The feet were only slightly swollen. No skin lessons were present except that the follicles and

other skin markings were greatly exaggerated Pitting could be choited with difficulty, but there was not a typical brawny sensation to the touch The feet were warm, of good color, and the pulses were easily felt There were no varicosities

Laboratory Findings —Blood count showed hemoglobin 13 5 Gm, white blood cells, 7,500, polymorphonuclear cells 63, lymphocytes 25, monocytes 12 Urine examination showed a specific gravity, 1 018, negative for albumin and glucose, occasional white blood cell and hyaline casts per low power field Blood chemistry tests showed blood proteins 8 Gm, albumin 5 3, globulin 2 7, albumin-globulin ratio 1 9, urca nitrogen 22, creatinine 1 7, cholesterol 192, blood sugar, 118 The Wassermann test was nega-



Fig 1 Appearance before therapy was instituted Note that the edema is restricted largely to the ankles Elephantic skin markings are present The patient's weight was 287 pounds

The electrocardiogram was normal except for left axis deviation. A chest x ray showed increase in the transverse diameter of the heart with preponder ance of the left ventricular border, clongation, and

tortuosity of the aorta

Course in the Hospital —Complete bed rest, with fluid restricted to 1 200 cc daily, and salt restriction The legs were elevated 18 inches above heart level On this simple regimen she had a tremendous diuresis. At the end of six days she had lost 41 pounds in weight with an average loss of 3 250 cc of fluid daily The less were greatly reduced in size but were still edematous in the dependent portions. During the next six days she lost an additional 6 pounds but it was now evident that the diuresis had ceased this point latex rubber bandages 1/12 inch thick 8 inches wide, and 9 feet long, were applied to the legs The tension was adjusted so that most of the con striction was at the ankles. Another diuresis began immediately, and in three days she lost an additional 4 pounds. She was now discharged with instructions to elevate her legs at night and to wear the latex At home she continued bandages during the day to lose weight, so that at the end of one month the weight was 229 pounds a total loss of 58 pounds The circumference of the ankle was now 15 inches Naturally she was overloyed at her prog rest, this being the first time in ten years that she Another remarkable could walk without difficulty feature was the disappearance of the characteristic resemblance of elephantiasis in the skin the skin was loose it was not as redundant as might be expected

Comment.-To what cause may the edema be attributed in this case? A cardiac origin is unlikely because of the absence of venous distension and other signs of right heart failure, plus the normal electrocardiogram. The heart was found enlarged at x-my examination, but this was expected in view of the coexistent hypertension The normal urine Venous and blood chemistry obviate a ronal origin stans and lymphatic block cannot be considered for at a cosmetic operation two months later the surgeon found no evidence of either condition. Moreover, a biopsy of the skin taken at this time showed normal cutaneous and subcutaneous structure. Nutritional edema is ruled out in view of the excellent general nutrition, hemoglobin, and blood proteins. There is nothing in the history, course and other findings to

suggest an infectious origin

One simple logical cause remains low tissue pressure. It is to be recalled that the patient was a large woman, 5 feet 7 inches tall and that she was once very obese A large portion of the adipose tissue was in the legs. With reduction in weight the thin of the legs, especially the ankles, was left very loose. Here, where filtration pressure is normally high, edema began to form Thus, a vicious cycle was instrated in which edema formation was followed by further stretching of the skin and subcutaneous thence, naturally making a larger collection of fluid possible, until over the years the woman's legs reached an enormous size. An additional circum stance to support this theory is the fact that when water balance became stationary on bed rest and devation of the legs, a further diureus was obtained by application of the latex rubber bandages. This



Fro 2 Appearance after the application of latex rubber bandagos. These are applied over a light octton stocking to prevent chaing of the skin The winding is begun at the arch of the foot, most tension being applied here and at the ankle to render proper support without constricting bands. The patient found the bandages hot but not uncomfortable.

obviously had the effect of increasing tissue pressure Indeed one sees edema formation developing in the legs of obese women without an inciting cause other than a low tassue pressure. The use of latex bandages in such patients is suggested

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BILATERAL FEMORAL ARTERIAL ANEURYSMS

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BILATERAL femoral arterial aneurysms are sufficiently rare to warrant this report of another case 1-7

Case Report

N K, an 83-year-old white man, was first seen in the clinic on July 2, 1947—Intermittent claudication in the lower extremities after walking one block had been present for two years—The pain in the left lower extremity extended down the thigh as far as the ankle. The pain in the right lower extremity was limited to the lateral part of the thigh—Swellings in both femoral regions had been noted for five

years by the patient

Physical examination revealed a fairly well-developed and nourished elderly white man The pupils were equal and regular and reacted promptly to light Cataracts were present in both eyes. The light Cataracts were present in both eyes patient was edentulous There were no dilated neck veins The spine revealed mild Lyphoscoliosis The lungs were clear The heart was not enlarged There were no murmurs. The second sound at the aortic area was louder than the second sound at the pulmonic area. The blood pressure was 140/80 pulmonic area. The blood pressure was 140/80 There was no enlargement of the liver or spleen A right, indirect, incomplete, reducible inguinal hernia was present. There were globular-shaped femoral arterial aneurysms located in Scarpa's triangle on each side (Figs 1 and 2) The aneurysm of the left side was $2^{1}/_{2}$ by $1^{2}/_{4}$ inches, the right aneurysm measured $1^{1}/_{2}$ by $1^{2}/_{4}$ inches Bruits were heard over both aneurysms, the left bruit being faint and the right loud. There were no dilated veins, nor was there any enlargement of the lower extremities Pulsations in the popliteals, posterior tibials, and the dorsal pedis vessels were not elicited No marked trophic changes were noted in the skin of the feet

Oscillometric readings were as follows left ankle, 0 25 at 100 mm of mercury, right ankle, 0, left calf, 0 5 at 140 mm of mercury, right calf, 0 25 at 100 mm of mercury. The electrocardiogram which was taken on July 7, 1947, was normal, and a roent-genogram of the chest taken on the same day showed considerable emphysema in both lungs. There

were a few infiltrations of the left lower lobe. The heart was normal in size and shape. The dorsal spine showed slight scoliosis with a convexity to the left. Roentgenograms of both lower extremities taken on July 16, 1947, showed bilateral extensive calcifications of the posterior tibial, popliteal, and femoral arteries (Fig. 3)

The blood Wassermann was negative. The blood cholesterol was 183 mg per cent. Urinalysis revealed a specific gravity of 1 020 with no sugar, albu-

min, or microscopic abnormalities

Comment

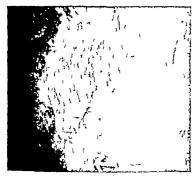
The above case is, to our knowledge, the ninth such recorded in the world literature (Table 1). The ages ranged from twenty-four to eighty-three with an average of fifty-four years. There was no predominant etiology. In two cases the aneurysms were due to arteriosclerosis, in three to syphilis, in three to endarteritis, and in one to a congenital lesion. Allen, Barker, and Hines state that arteriosclerosis is the most common cause of aneurysms of the lower extremities and, less commonly, mycotic arteritis, necrotizing arteritis, and trauma.

The usual sites of aneurysms of the lower extremities are the popliteal space and Scarpa's triangle. This is believed to be due to less muscle protection in these regions and to the fact that the frequent bending to which these sites are subjected may tend further to weaken a diseased intima and cause medial degeneration with subsequent aneurysmal formation. Matas stated that aneurysms of the superficial femoral arteries are about ten times more frequent than those of the deep femoral arteries and about four times less common than those of the popliteal arteries. Of eight bilateral femoral aneurysms in which the location was reported, ten were in Scarpa's triangle, and six were in the adductor canal.

The most frequent treatment in the cases reported was ligation of the arteries proximal to the aneurysm In the most recent case, however, a bilateral, obliterative endo-aneurysmorrhaphy was performed

TABLE 1 -SALIENT DATA IN NINE CASES OF BILATERAL FEMORAL ARTERIAL ANEURYSUS

Author	Age	Etiology	Location	Treatment	Complications
Godlee ¹	34	Arterial disease (?) manifest in superfi- cial vessels	Lower portion of ad- ductor canal	Femoral artery li- gated in Scarpa's triangle bilaterally	,
Dreesman ²	55	Lues	Upper portion of ad- ductor canal	(one year apart)	
Lousteau ²	64	Arteriosclerosis	Scarpa's triangle		Gangrene of foot
Franket	68	Endarteritis	Scarps s triangle	Left—double ligation Right—extrepation	Cangitate of 1000
Aspinsli ^s	24	Chronic streptocorcal septicemia produc- ing vascular disease	Scarpa's triangle	Proximal ligation of both femoral arteries	
Diletti	63	Lues	Scarpa s triangle	Surgical and anti-	
Pancale (quoted by Dilettie)		Lues		tabero	
Theron 7	38	Congenital localized deficiency of arter- ial walls	Proximal end of ad- ductor canal	Bilateral obliterative endo-aneurysmor- rhaphy	Hemorrhage neces- sitating the surgi-
Rogers and Rinzler	83	Arteriosclerosis	Scarpa's triangle	tuapuj	cal procedure



Arrow indicates Left lower extremity ancuryam of left femoral artery in region of Scarpa a triangle.

The ancurysms in our patient were of approximately five years duration. Symptoms of intermittent claudication were present for two years. The diagnosis was made by the palpation of an expansile pulsating mass bilaterally (Figs. 1 and 2) by the sys-



Arrows Indicate Lower extremities. location of aneurysms of right and left femoral arteries.



Fig. 3 \\\\-ray of pelvic area to show calcification of femoral vessels at level of Scarpa's triangle.

tolic bruits and by the presence of calcification in the ancurysmal areas (Fig. 3) We did not believe that arteriography was essential to the diagnosis. Arteriovenous ancuryam could be ruled out by the absence of history of trauma, by the bilateral hature of the lesions by the lack of machinery-like bruits and thrills and by the absence of dilated veins or en larged lower extremities No surgical intervention nas attempted because of the patient s age absence of gross symptoms absence of progression of the lesions and the presence of a moderately severe degree of calcification of the entire femoral arteries. He was treated conservatively in an effort to main tain the collateral circulation.

In view of the frequency of arteriosclerotic peripheral vascular disease, it is surprising that bilateral femoral ancurysms are not more common

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WHO NOSE BEST?

Returning to the village of his birth the proud new doctor decided to call on the old family physician. I suppose that you intend to specialize, remarked the older man

Oh, yes replied the youth 'in the diseases of

the nose for the ears and throat are too complicated to be combined with the nose for study and treatment.

Thereupon the family physician inquired 'Which nostril are you concentrating on?

SOLITARY DIVERTICULUM OF THE CECUM

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SOLITARY diverticulum of the cecum with inflammatory changes is an uncommon lesion masmuch as a review of the literature reveals a total of only 48 previously reported cases 1

Most authors are agreed that patients are usually operated on with a preoperative diagnosis of appen-

dicitis, as was true in our case

The majority of diverticuli have been found on the lateral wall of the cecum The lesion is most commonly thought to be either a solitary ulcer of the cecum, such as has been described by Cameron, Barrow, and Wilkie 2-4 These authors report that most simple ulcers usually occur on the medial wall The other lesson most frequently thought of, either preoperatively or at the operating table, and sometimes almost impossible to differentiate, is carcinoma of the cecum.

Most authors are agreed that if the diagnosis can be made, minimal surgery should be done Schnug, in a report on six cases of diverticulities of the cecum, recommends only the most minimal surgery 5

All types of operations have been done, including diverticulectomy, inversion of the diverticulum, closure of the perforation, primary resection of the cecum and/or ascending colon, anastomosis, and drainage The results usually have been good, inasmuch as there have been only two reported deaths

Case Report

K. F, a 43-year-old, white widow, was admitted to the surgical service on January 30, 1947, with a history of cramping midepigastric pains with radiation to the right lower quadrant. The patient felt The duration of the nauseous but had not vomited There was no associated diarpain was one day The patient gave a history of chronic constipation and had had no bowel movement for two days preceding her entry into the hospital The pain in the right lower quadrant on admission had become

exquisite

Physical examination revealed an acutely ill, wellnourished white woman of good hemic component On abdominal examination, there was marked tenderness over McBurney's point, rebound tenderness, and spasticity of the right lower quadrant. There was no abdominal distention, and no masses could be definitely palpated Rectal examination showed no masses, but there was definite tenderness on the right side Vaginal examination was nega-The temperature was 100 F, and the pulse rate 90 per minute The urine was normal, hemoglobin 88 per cent, white blood cells 21,200, differential, 78 per cent polymorphonuclears, 17 per cent lymphocytes, 3 per cent mononuclears, 1 per cent basophils, and 1 per cent eosinophils The preopera-tive diagnosis was acute appendicitis On the day of admission, an operation was performed abdomen was opened through a McBurney incision, and the appendix was found to be slightly injected

On the anterolateral wall of the cecum there was a firm, grayish, ovoid plaque 3 cm by 2 cm, slightly raised above the surrounding cecal wall On palpation through the thickness of the wall, the plaque gave one the impression of having a rolled mucosal margin with a central crater There did not appear to be any lymphadenopathy present A diagnosis of early ulcerocarcinoma of the cecum was made, and, masmuch as the patient was not prepared for a colonic resection, it was deemed advisable to exteriorize the terminal ileum, cecum, and ascending colon after mobilization in a Mikulicz-like procedure February 2, 1947, a biopsy of the plaque was taken up to, but not through, the mucosa

The pathologist's report of the specimen was granulation tissue with no evidence of malignancy On February 4, a cecostomy was done for decompres-On February 5, the exteriorized loop was resected with the cautery, leaving a double-barrelled The spur was crushed, and on ileocolostomy March 21 an extraperatoneal closure of the stoma The patient was discharged on April 2 was done

in good condition
Pathological Examination—The specimen consisted of a segment of terminal ileum, cecum, and proximal portion of ascending colon measuring 17 On the lateral wall of the cecum, an cm, in length indurated, grayish plaque, 4 cm in diameter, was On section, the mucosa of the ileum and cecum was edematous but otherwise intact, except for a point 2 cm. from the appendicular opening At this point a solitary diverticulum was found measuring 2.5 cm in depth, the neck of which was 0.7 cm across. The peridivorticular serosa, as well as the scrosa of the adjacent appendix, was covered by a firmly adherent, yellow-white exudate A cecostomy opening was identified at the apex of the ce-The appendix proper showed no gross abnorcum malities of its wall

Microscopic Description —There was an abrupt loss of muscularis in the region of the neck of the di-The remainder of the diverticular wall verticulum was composed of mucosa and muscularis mucosae The subserosal tissues were thickened markedly by an extensive inflammatory exudate composed of a large number of mononuclear leukocytes, lymphocytes, and a moderate number of neutrophils Granulation tissue was evident at the periphery of the inflamed subserosa, and large plaques of partially organized fibrin were seen covering the granulation tissue At two points in the wall of the diverticulum there were small ulcerations of the mucosa with abundant underlying acute inflammatory

Diagnosis —Solitary diverticulities of cecum with extensive organizing pericecal inflammation

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FEVER OF UNDETERMINED ETIOLOGY ASSOCIATED WITH BRONCHOPNELL MONIA, CONIUNCTIVITIS, STOMATITIS AND ADENOPATHY (STEVENS JOHNSON SYNDROME)

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(From the Medical Service of the Albany Hospital)

RECENT reports have devoted increasing attention to a clinical complex of undetermined cause characterized by involvement of the eye buccul cavity, respiratory tract skin and genitalia. The literature is well surveyed in two reports, and a conaderable number of new cases are added 12 It is noted in these studies that the syndrome may in rolveany or all of the systems mentioned above that the determining features of this selection are not known, and that careful pathologic scrologic and bacteriologic studies have failed to clucidate the CAUTE

Soll divides the clinical picture into three groups 1 The first, primarily affecting the skin with slight in volvement of the mucous membrane is the original crythema multiforme exudativium of Hebra second, characterized by severe destructive panophthalmite associated with extensive ond mucous membrane lesions and erythematou. maculopapular rash, was described by Stevens and Johnson 3 Into the third group falls most of the new cases reported by Soll' Most of these cases occurred in young men, who following prodround symptoms of the upper respiratory tract developed stomatitis with vesicles and pseudomembranes, fever occumorally bronchopneumona and balantis conjunctivitis was common but skin lesions and adenopathy were seen less frequently No urethral mvolvement or vaginitis was reported in the women This acute, febrile condition was felt to be self limited. Thorough bacteriologic viral and serologic studies revealed no single causative agent, although contaminants were noted frequently

The plethora of terms (Stevens-Johnson syndrome, crythema multiforme exudativum ectodermost crossyn pluriorificalis eruptive fever with stomatitie and ophthalmia) serves mainly to indirate the capricious involvement of any of a number of systems and gives no insight into the etiology or basic nature of the disease. It is suggested how ever, that the term "Stevens-Johnson syndrome be utilized until the causative agent can be determined ruce per se it indicates no specific organ complex and yet serves as an identifying term in the welter

of "fevers of undetermined origin

Case Report

A 13-year-old white girl was admitted to the Ai bring Hospital on October 16 1947 with the history of onset of a mid upper respiratory infection one work previously. This had persisted and three days prior to entry a moderately productive cough appeared, mucold material but no blood-streaked sputum, was noted. At this time full doses of sulfa diazine were begun The following day her temperature which had only been slightly elevated rose to 106 F orally this persisted to the time of ad inneion. One day before entry she developed a rapidly spreading stomatitis associated with a rather severe sore throat. At this time, she was given one injection of 300 000 units of penicillin in oil

She had no nausea comiting chills myalma retrobulbar pain skin ra h or insect bites, no other members of her family presented similar symptoms, she had had no contact with rabbits or diseased birds, Her past history family lustory and social history were of no significance in the present illness

Physical examination on entry revealed an acutely ill girl with a temperature of 10 F pulse 145, respiration, 32 and blood pressure 120/75 There were enlarged, discrete moderately firm bilateral anterior cervical lymph nodes. No abnormalities were noted in the bones joints or muscles. There was no evidence of rash or other abnormality of the There was periorbital edema and injection with belphoritis and severe conjunctivities with a profuse mucopurulent exudate. Lars were negative. The name were injected, and the posterior naso-placture showed a grayish pseudomembrane. The mouth was the site of a diffuse process which extended from the vermilion border of the lips to the pharyny it was characterized by vesicle formation which coalesced to form a dirty grayish, non bleeding pseudomembrane over the entire bureal cavity. The chest revealed bilateral posterior medum inspiratory moist rales with some wheezer and rhoneld on expiration The heart was within nor mal limits except for a sinus tachy cardia no unusual findings were noted in the breasts abdomen or extremities Neurologic examination was negative The pelvie examination was obscured by a profuse menstrual flow

The laboratory findings on admission were as follows red blood cells 3 870,000, hemoglobin 82 per cent white blood cells 14 900. The differential count revealed 70 per cent polymorphonuclears, 12 per cent lymphocytes 1 per cent cosinophils and 8 per cent monocytes Corrected sedimentation rate was 44 mm per hour nonprotein nitrog in was 22 mg. per cent Urine was negative throughout the hospi tal course Blood cultures, aerobic and anaerobic tive, agglutination tests for Brucella were negative, agglutination tests for Brucella abortus B tularense, B typhosus were negative the heterophil antibody filer was of no positive sig-Cultures and smears of the mouth and pharynx were negative for Corynebacterium diphtherm. Sputum cultures revealed a few months. some contaminating organisms and on one occasion a pneumococcus type 8 but repeated cultures were without significance On one occasion unidentified gram-positive, spore-bearing bacilli were noted \o tuls rele bacilli were seen Cultures of the conjunctival exudate revealed coagulase-positive Staphylococcus aureus. Chest roentgenograms revenled bi

lateral branchopneumonia.

On entry, in view of her critical condition, the pa tient was placed on 60 000 units of penicillin intra muscularly every four hours and 2 (m of streptomyein were given followed by I Gm every six hours Supportive therapy in the form of intraven ous fluids penicillin eve washes and sedatives was provided. The temperature and pul e fell slowly over the first five days, and specific therapy was discontinued on the sixth hospital day. She remained in bed for eight days but improved rapidly after that and was allowed about the wards. The eye lesions disappeared with no residua, all but minimal lung signs disappeared, and the oral lesions improved markedly. At the time of her discharge on her eleventh hospital day her white blood count was normal, and only minimal pigmentation of the lips and buccal mucous membrane remained.

Comment

Another case belonging to the complex group of Stevens-Johnson syndrome is reported. It would fall into the third group of Soll, being of intermediate severity with no skin involvement and no ocular sequelae. While it cannot be said that the clinical improvement was due to the penicillin and streptomycin, the incidence of severe ocular sequelae in the era prior to specific chemotherapeutic agents makes it almost mandatory to offer such therapy to these

patients until a specific causative agent can be isolated

Summary

- 1 A febrile clinical complex of considerable severity associated with lesions of the respiratory tract, the eye, the lymph nodes, and the oral mucous membrane has been reported, no causative organism was isolated
- 2 It is felt that this represented a variant of the Stevens-Johnson syndrome

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Permission to publish this case was granted by Dr. Thomas Ordway, professor of medicine Albany Medical College on whose service the patient was observed

IRREDUCIBLE HERNIAS IN INFANCY

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(From the Children's Surgical Service, Bellevue Hospital)

IRREDUCIBLE hernias in infancy present one of the serious problems for which emergency surgical interference is indicated. Cases in which loops of bowel are entrapped intensify the urgency of the situation, as infants with gangrenous bowel tolerate bowel resection very poorly. The contents of hernial sacs may be quite varied. Among the various viscera involved, there may be included liver, spleen, bladder, intestines, ovary, and fallopian tube. The following two cases represent irreducible hernias recently admitted to the children's surgical service of Bellevue Hospital.

Case Reports

Case 1 —A baby boy was born on October 3, 1947, at 1 30 A.M. with a congenital irreducible umbilical hernia The pregnancy had been uneventful and the delivery normal At birth an intern had noted the hernia and had tied the cord long to avoid including "bowel" in the tie. The hernia measured about 2 cm in width and 4 cm in length child was apparently well except for the above and a moderate hypospadias Eighteen hours after birth, under general anesthesia (cyclopropane) the hernial sac was opened Its contents were noted to be the entire left lobe of the liver and loops of small bowel The liver was adherent by its lateral istal end of the hernial sac The adat the base edge to the distal end of the hernial sac hesion binding it was severed by sharp dissection, and the ensuing bleeding from the liver edge was controlled with gel-foam. The liver, together with the intestines, was replaced in the abdominal cavity, and after adequate anesthetic relaxation, the abdominal wall was sutured in layers with black silk The postoperative course was smooth, and the child left the hospital thirteen days postoperatively taking his formula well and having gained in weight He was discharged on October 16, 1947, and on his return to our follow-up clinic, he appeared in excellent health with his wound well healed

Case 2 — A baby girl was three weeks of age when her mother noticed a swelling in her right groin The child had been vomiting and appeared fretful for the thirty-six hours prior to admission to the hos-Her history included the passage of normal stools per rectum twenty-four hours before hospitalization Attempts at reducing the hernia in the outpatient department had been only partly successful, since a portion of the mass remained present. Physical examination on admission revealed a three-week-old infant crying continuously and apparently in pain. The abdomen was moderately distended, and a right inguinal hernia was The hernia mass was about 2 cm in diameter, somewhat indurated, and nonreducible by gentle taxis Crying would tense the consistency of She was mildly dehydrated

After adequate preoperative parenteral fluids were administered, a right inguinal hermorrhophy was performed under general anesthesia. Through a 3-cm inguinal incision, the inguinal canal was entered. The herma sac was opened, and its contents revealed the right ovary with the fimbriated end of the right tube. The tube and ovary were replaced in the peritoneal cavity and the sac ligated. The wound was closed in layers with black silk. The postoperative course was smooth. The wound healed well, and the child left the hospital gaining weight. Return to follow-up clinic revealed a well-healed right inguinal wound and a normal, healthy child.

Summary

Two cases are presented which fall into the category of acute surgical emergencies in children Irreducible hernias which progress to gangrene of abdominal viscera, especially intestine, present a dangerous threat to life, as infants withstand intestinal resection very badly

640 PARK AVENUE

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NECROLOGY

John C M Brust, M D, of Syracuse, died on May 14 at the age of forty-two Dr Brust was graduated from Syracuse University, College of Medicine, in 1929 A diplomate of the American Board of Surgery, he served as associate proctologist on the staffs of Syracuse University and Syracuse Me-morial Hospitals and as proctologist at the Syracuse Free Dispensary Dr Brust was a member of the American Proctologic Society, the Syracuse Academy of Medicine, and the Alumni Association of Methodist Hospital, as well as the American Medical Association and the New York State and Onondaga County Medical Societies

Reid Gilmore, MD, died on April 28 at his home in Schenectady He was seventy-two Dr Gilmore was graduated from Albany Medical College in 1900 and interned at Ellis Hospital, Schenectady tired from practice in 1946, Dr Gilmore was a member of the American Medical Association and the New York State and Schenectady County Medical

Lester B Lougee, MD, of Marilla, died re-ntly His age was seventy-five Dr Lougee was graduated from Physio-Medical College in Indiana in 1886 He was a member of the American Medical Association, the American School Health Association, and the Erie County and New York State

Medical Societies

Robert E A. Milne, M.D., of Le Roy, died on May 4 at the age of forty-eight A native of Canada, Dr Milne was graduated from Toronto University Medical School in 1935 He served as a physician with the rank of major in the 41st Service Group of the United States Army Air Corps in the Mediterranean Theater during World War II Dr Milne was a physician on the staff of Genesee Memorial Hospital, Batavia, and was a member of the American Medical Association and the New York State and Genesee County Medical Societies

Philip E Rossiter, M.D., died on April 30 in von He was seventy-one years old Dr Rossiter was a graduate of Long Island College Hospital in 1902 He enlisted in the Army in 1916 and was stationed in Hawaii at the outbreak of the war After the war he served in the United States Veterans Bureau, retiring with the rank of major Dr Rossiter entered private practice at Chemung in 1927 and at one time had been a member of the staff of Sea View Hospital, Staten Island, and of Tioga County General Hospital, Waverly He was a member of the American Medical Association and the New York State and Livingston County Medical Societies

Fenton Taylor, M D, saxty, died at his New York City home on May 26 Dr Taylor was graduated from the College of Physicians and Surgeons, Columbia University, in 1913 He joined the British Army in 1916 and won the British Military Cross for gallantry in action with the 1st Leicestershire Brigade in France He later served with the American Red Cross and the American Expeditionary Force in France, attaining the rank of major in the Army Medical Corps An alumnus of Sloane and Presby-terian Hospitals, Dr Taylor had served as head of the Cornell Surgical Division of Bellevue Hospital Recently, he had been a consulting surgeon to the Southampton Hospital, Southampton, and the New York Hospital, New York City Dr Taylor was a member of the American Medical Association and the New York State and County Medical Societies

John George Vaughan, M D, White Plains, died May 18 at the age of sixty-nine He was graduated from Northwestern University Medical School in 1907 and also studied at the London School of Tropical Medicine In 1909 he was named a medical missionary for the Methodist Church and served for nine years in Nanchang, Kiangsi Province, be-coming superintendent of Nanchang Hospital and medical adviser to the city of Nanchang From 1924 to 1929 he was again in China as superintendent of the Wuhu General Hospital on the Yangtze Dr Vaughan was director of the Associated Mission Medical Office in New York City He was a fellow of the American Medical Association and a member of the China Medical Association, the American Society of Tropical Medicine, the New York Society of Tropical Medicine, and the New York State and Westchester County Medical Societies

Frank Vero, M D, New York City, died on May He was fifty years old Born in Czechoslovakia, he was graduated from Bratislava in 1922 and took a postgraduate course in dermatology at the University of Vienna University of Vienna He came to the United States and interned at the United States Public Health Service Marine Hospital, No 70, in 1923 Dr Vero was on the attending staffs of Polyclinic and Presbyterian Hospitals and of the Vanderbilt Clinic of Columbia-Presbyterian Medical Center He was a diplomate of the American Board of Dermatology and Syphilology and a member of the American Medical Association, the American Academy of Dermatology and Syphilology, the Society for Investigative Dermatology, and the New York State and County Medical Societies

APPROVES ALLOWANCES FOR DISABLED VETERAN'S DEPENDENTS

The House Veterans Committee unanimously approved a bill to give \$61,800,000 in special allowances to dependents of 130,700 veterans with dis-The bill, if finally abilities of 60 per cent or more approved, would for the first time establish benefits for dependents of disabled men
It would give these

allowances to dependents of totally disabled veterans of World Wars I and II wife, \$30 a month, first child, \$20, next two children, \$15 each, dependent mother or father, \$25 each

The allowances would be reduced for lesser disabilities -J A M A, April 17, 1948

ABSTRACT OF MINUTES OF THE COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

AT ITS meeting on April 8 1948 the Council considered the following matters, taking action as indicated

Secretary s Report

Remassion of State Assessments,-Remassion of State assessments was voted on account of service with the armed forces for seven members for 1948. 183 for 1947, and one for 1946, also on account of filness for the following members according to county Monroe Ira M. Olsan 1948 Harold L. St. John, 1948 John M. Swan 1947 Queens Paul Recenthal, 1947

Meetings -During the past month your Secretary has taken pleasure in attending meetings of Council Committees and Subcommittees and in handling correspondence. On March 10 at Dr Bauer's request, I represented the Society at the dinner of the National Council on Rehabilitation

Arrangements have been completed by Mr Frederick W Michael Director Information Serv ice, Public Relations Bureau, for a dinner to be tendered in the name of our Society to the Council of the World Medical Association at the Hotel Biltmore on Wednesday April 28. Invitations have been sent to the Trustees the Councillors officers, and those who attend Council meetings as invited guests to subscribe for and attend thus dinner

Preparations for the Annual Convention have been progressing smoothly Arrangements for registration, teaching day section meetings, the Annual Meeting and dinner exhibits-both scientific Arrangements for and technical—and for the meeting of the Woman s It is anticipated that

Auxiliary, are all under way It the meeting will be well attended

As this Annual Meeting is scheduled May 17 to 21 the question arises whether or not you desire to meet the second Thursday in May which would be May 13 only three days before the House convenes It is presumed that the Council will organize im mediately after the House of Delegates adjourns, probably on May 19 and that you will again meet on Thursday June 10 at the State Society's office at 0 00 A.M.

It was roled not to meet the second Thursday in May in this office as the Council will organize immediately after the House of Delegates adjourns

May 19

As a supplementary report the Secretary stated he went to Philadelphia the previous Sunday morning to a meeting of the Executive Committee of the Middle Atlantic States Council on Medical Service of the American Medical Association to represent

Dr Aranow Vote of Appreciation to Dr Bauer -Dr Beek man moved that inasmuch as this was the last meeting at which Dr Bauer will act as chairman that the Council pass a motion regretting that he is not to continue as chairman at further meetings and of approciation for what has been done for us during

the last year

The Secretary put the motion which was carried

The Secretary put the motion which was carried by all the members arising and applauding.

Dr Bauer replied as follows
Gentlemen, Dr Beekman kind of caught me
Gentlemen, La Beekman kind of caught me
unaware. I had intended as the last thing this
unaware. I had intended as the last thing to the Council morning to express my appreciation to the Council for their unfailing cooperation during the past year

I don t think that any president could carry on the job satisfactorily if he did not have that wholehearted cooperation and I want to say that I have always had it not only from the Council but from the members who have served on committees, etc., and from the local headquarters staff Dr Anderton and Mr Anderson and others here in the headquar ters office have taken a tremendous load off my shoulders, and I want to say that it has been a very high privilege to preside over you during the past I have enjoyed it, although I must confees that I am not shedding any tears that it is about over because it has been rather a long year you know I had four months more than I should have had because of the untimely death of Dr Hale.

All I can say is that I appreciate very much having been associated with you. You will probably have to tolerate me around for another year as a member of the Council, but I can sit down there with you then Again I want to thank you for

your very patient consideration.

Communications—Letter from Dr J David Hammond secretary of the Modical Society of the County of Cayuga March 25 1948 regarding the desirability of taking free chest x rays for anybody at Auburn City Hospital

After discussion, it was roted that the Secretary roply stating that the State Society is of the opinion that this is a local matter which the County Society ought to determine and that he invite their attention to the fact that the proposition probably is intended to pertain to tubercu losis only which is in line with the State drive toward its cradication

Letter March 25 1948, with resolution from Dr. B Wallace Hamilton, secretary Medical Society of the County of Vew York, supporting the Associa tion of the Bar of the City of New York in its efforts to have Congress enact the Silverson Plan of old age security or some modification thereof was read for information.

A letter of April 2 1948 from Dr DeWitt Stetten. secretary of the United Medical Service, Inc., was read by Dr Anderton This letter expressed disread by Dr Anderton This letter expressed dis-approval of the action of the A.M.A. in discarding the Blue Cross coverage in favor of commercial

inaurance.

After discussion at was roted to refer this letter to our A.M A. delegates without instructions.

Letter March 19 1948, from Mr Royal W Ryan, executive vice-president New York Convention and Visitors Bureau Inc inviting the American Medical Association to hold their interim meeting in New lork City in 1949 was considered. As a result, Dr B Wallace Hamilton secretary of the Medical Society of the County of New York, on March 15 1948, sent the following letter

Dear Doctor Anderton:
The Comitia Minora of the Medical Society of the County of New York beg to extend a warm and cordial invitation to the American Medical Association to hold intering Beating of the American Medical Association to New York City in Demonstrate Medical Association in New York City in Demonstrate and deeply grateful to be boots on American Medical Association and would much appreciate the courtesy of your extending this official much appreciate the courtesy of your extending this official

invitation.
On behalf of the Comitia Minora, I beg to remain, etc. It was roled that the Council invite the American Medical Association to hold its interim session in 1949 in New York City

A letter under date of April 2, 1948, from Dr J L Dolhinow, president, House Staff Council, A.I MS, Psychiatric Division, Bellevue Hospital, New York City, re National Physicians Committee was read and voted to be placed on file

A letter under date of April 2, 1948, from Dr Goodlatte B Gilmore, secretary, Bron County Medical Society, was read by the Secretary

We have a list of approximately a dozen men who according to our records, entered military service in 1942 and 1943 Although it could be reasonably assumed that these physicians have been discharged they have never communicated with our offices, and letters forwarded to them at their most recent mailing addresses have been returned.

turned.

In accordance with the regulations of the State Society we have had their dues remitted through the year 1947 However before requesting remission of their 1948 dues we would like to know if the State Medical Society has placed any limitation on the period for the remission of dues when there is no information available on the doctor. Will you kindly let me know at your very earliest convenience whether we should request the remission of their 1948 assessments, or whether we should resign them from membership as of December 31, 1947

Letter under date of March 26, 1948, from Dr Ivan N Peterson, secretary, Medical Society of the County of Tioga, was read by Dr Anderton

Before this county society requests remission of assessments for this physician I would like your opinion in the

Dr Knight has disposed of his real estate in this county and removed permanently from here from what informa-tion I can gather He has told some friends he expects to stay permanently in the Army

Under these circumstances and with no resignation from the society by the physician can we drop him from mem-bership or should we continue to carry him as a member in

the service?

After discussion, it was voted that the county societies, in both cases, be advised that they may drop these men without prejudice to their right to be reinstated

Letters from Mr Abraham Orlofsky, dated March 9, 1948, and April 5, 1948, to President Bauer advocating the establishment of a permanent regulatory hospital commission in New York.

It was voted to refer these letters to the Committee on Economics

Letter from Dr Bauer, dated April 1, 1948, to Dr Jacob L Lochner, Jr, secretary, New York State Board of Medical Examiners, as follows

Dear Doctor Lochner
The officers and other members of the Council of the
Medical Society of the State of New York are anxious to
know the present atuation in regard to issuing licenses to
practice medicine to graduates of the Middlesex (Massachusetts) Medical School Are there or are there contemplated, any new developments about licensing such men,
or is the situation closed?

Dr Lochner replied to Dr Bauer under date of Aprıl 2, 1948

Dear Dr Bauer

This will acknowledge receipt of your letter of April 1 in which you inquire about the present situation in regard to medical licensure for graduates of Middlesex Medical School

School

Please be advised that there are at present approximately thirty-five graduates of Middlesex Medical School planning to petition the Board of Regents for permission to take the New York State Medical licensing examination. One of these cases is on the calendar for the meeting of the Regents Committee on Licenses which will be held in New York City on April 8 The Special Committee set up by the Department to pass on applications from graduates of unapproved medical schools has rejected the applications of this entire group I have advised the Department and the Regents Committee on Licensure previously that it is

my opinion that these boys have only had three years of medical study since the School was closed before they re-ceived their diplomas

If there is any further information you desire please let

me know

After discussion, it was voted that the Council protest to the Board of Regents and to the Commissioner of Education about licensing men with unfinished training, and admitting to practice foreign graduates without taking the State examinations

Treasurer's Report was accepted

Report of Executive Officer

Dr Hannon, chairman, reported "The Legislature adjourned Saturday, March 13 The Governor has until midnight of April 12 to com-This session of the Legislaplete the thirty-day bills ture was one of the shortest on record It had the greatest number of bills, however, that had ever been introduced There were over 5,500 There were over 1,100 bills passed by both houses that went to the Governor The Governor had considered all but 200 of those bills up to yesterday when I left

Albany

"The four bills that pertain to the State university and the control of future colleges, etc., have been signed by the Governor The bill that was introduced during the last session of the Legislature in regard to discrimination in education has also been signed by the Governor There are only two bills in the hands of the Governor at the present time that have not been acted on, which we have followed One pertains to the medical commission, to the boxing commission or athletic commission which we favored, the other is a bill pertaining to tuberculosis, upon which we had not taken action. The bill that permitted the telephoning of prescriptions, which I was instructed through the action of the Council last month to put in an objection upon, has been vetoed by the Governor"

Activities of Committees

Constitution and Bylaws.—Dr Reuling, chairman, reported that Amendments to the Constitution and Bylaws of the Medical Society of the County of Orange, under date of March 29, were forwarded to the Secretary who has referred them to the Committee and the Counsel of the Society there was nothing in them to conflict with the Constitution and Bylaws of the State Society and that the Committee recommended approval.

The Council voted approval

Malpractice Insurance and Defense Board.—Dr Anderton reported that "Before the last meeting there was distributed to members of the Council a report of the Subcommittee on Malpractice Insurance and Defense Board regarding the study that has been made about the advisability or the madvisability of having an insurance company under the auspices of the Medical Society of the State of New York to carry our malpractice defense and insurance"

After discussion, it was voted that this report be referred to the House of Delegates with the statement that this study appears to have been made by two insurance representatives, one from the Society and one from outside, and that on the basis of the report it would seem madvisable for the Society to undertake the formation of its own insurance company at the present time, that, however, this is only one opinion, and before any intelligent decision can be reached the matter

[Continued on page 1412]



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[Continued from page 1410]

should be further studied and opinions from other groups obtained

Dr Albert F R Andresen requested that a copy of this action and of the report be sent promptly to the Reference Committee of the House of Delegates

Dr Anderton read the following letter from Dr Thomas M D'Angelo, chairman of the Malpractice Insurance and Defense Board, under date of March 31, 1948

Dear Doctor Anderton
The House of Delegates which met in New York City in
1946 ordered an annual audit of the Group Plan of Malpractice Insurance and Defense by certified public accountants
and that the audit be sent to the component county societically account to the matter of the ties not less than thirty days prior to the meeting of the House of Delegates

At Buffalo in 1947 the House of Delegates approved the report of the Reference Committee on Report of Malpractice Insurance and Defense Board which in part reads as

follows

RESOLVED that upon direction of this House or the Council our audit be made by an insurance actuary or

actuaries.

No provision was made in this resolution for the date or disposition of the audit (see page 2216 New York State Journal of Medicine, October 15 1947)

The records of the Group Plan for the period ending December 31 1947, have now been completed and are ready for audit Will you please advise whether it is desired to have the audit made by the accountants of the Society or by an insurance actuary, in either case whether it is desired that this Board arrange for the audit? If the arrangements are made by your office it is requested that arrangements are made by your office it is requested that the accountants or actuaries be instructed to carry out the audit under the direction of this Board so as to carry out the intent of the Society and avoid a situation such as occurred last year. In this connection it is pointed out that a complete check of the closed vouchers up to the end of 1946 was made last year and it should not be necessary to incur the expense of repeating that part of the audit

After discussion, it was voted that this be referred to the Board of Trustees with a statement that due to an oversight no arrangements have been made for the audit of the Malpractice Insurance and Defense accounts for the past year, that the results of that audit are supposed to be sent to the county societies thirty days prior to the annual meeting, that \$1,000 appears in the budget for this audit, and that would appear to be the approximate cost, that the Council requests the Board of Trustees to designate the auditor and arrange for this audit so the results can be known as soon before the Annual Meeting as possible

Planning Committee for Medical Policies -Dr Kenney, chairman, submitted summary of the activities of the Committee for the information of the Council Details of these activities will be presented in the Committee's Annual Report
Public Health and Education—Dr Mitchell,

chairman, reported as follows

"March 24, 1948—In New York City attended the meeting of the Planning Committee for Medical Policies

"April 6, 1948 -In New York City attended a meeting of the Council Committee on Public Health and Education with the Subcommittee on Child Welfare and representatives of the State Department of Health This conference was held at the request of the State Department of Health to discuss the compensation of physicians who are to participate in a pediatric consultation service and also a fee schedule for laboratory services plan under which they are operating was approved, subject to possible future changes based upon suggestions from us

"April 7, 1948 -In New York City to attend a meeting of the Subcommittee on Cults of the Council Committee on Legislation

"April 8, 1948 -In New York City there will be

a meeting of the Council Committee on Public Health and Education and the Subcommittee on Cancer with representatives of the State Department of Health "

Postgraduate Education -Postgraduate instruction has been completed in the following counties Cavuga, Fulton, Onondaga, Richmond, Schenectady and Tompkins

Postgraduate instruction is being given in the following counties Clinton, Jefferson, Madison, Nassau, Oneida, Ontario, Oswego, Rockland, St. Lawrence, Saratoga, Sullivan, Tioga, and Ulster

A Regional Teaching Day consisting of five lectures on miscellaneous subjects has been arranged for the Genesee County Medical Society This meeting will be held in Rochester on April 21, 1948 The memberships of the following county medical societies will be invited to attend this session Genesee, Orleans, Wyoming, and Livingston

A symposium on medical rehabilitation of children suffering from cerebral palsy and polio has been arranged for the Nassau County Medical Society

and will be held on May 25, 1948

A Teaching Day on Nontuberculous Pulmonary Disease is being arranged for the Queens County Medical Society to be held on May 14, 1948, in Jamaica and Forest Hills

Public Relations -Dr Winslow, chairman, pre-

sented the following report

"The Public Relations Bureau has issued 20,000 Years of Service, the commemorative honoring those physicians in New York State who have practiced medicine fifty years or more date, booklets have been mailed to the following the fifty-year men, members of the Council, House of Delegates of the State Medical Society, County Society officers, district branch officers, legislative chairmen, presidents and secretaries of all other state societies, the editors of dailies in New York State, and exchange medical journals The total mailing numbers approximately 1,100 Requests have come in for more copies from the fifty-year doctors with letters of appreciation for the booklet

"Bulletin 6 was mailed to State officers, county presidents, and county legislative chairmen of the Woman's Auxiliary This bulletin congratulated the Woman's Auxiliary for the work which it did to

defeat the chiropractic bill

"A News Letter was mailed March 26, congratulating those who assisted in legislation this year, particularly the Woman's Auxiliary who aided in defeating the chiropractic bill Reprints of the Reader's Digest article, "Our Most Dangerous Lobby—II" were enclosed and orders are being filled for these A JOURNAL reprint of an editorial on District Branches was also included with the News Letter

"A newspaper release entitled "The Six New York State Non-Profit Voluntary Medical Care Plans" was sent to all the weeklies and dailies in the State This release was based on an announcement made by Dr Carlton E Wertz, chairman of the Committee

on Economics

"The following postgraduate sessions held under the auspices of the Committee on Public Health and Education were covered by releases to the press Cayuga, Clinton, Fulton, Jefferson, Madison, Nassau, Onondaga, Ontario, Richmond, St. Lawrence, and Tompkins

"Orders for Check and Double Check are still coming in from other states. The pamphlet was used by the Investors League at a hearing in Washington last month Mr Anderson conferred with

[Continued on page 1414]

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(Excerpts from N.Y. State J.I. of Medicine-October 1945)

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Graves' Syndrome and Disorders of the Colon — Of a total of 774 cases the association of these two disorders was 11 2 per cent It is of interest that of this total, 9 7 per cent were cases of mucous and spastic "colitis", while only 1 5 per cent were cases of ulcerative colitis In most of the latter, a history was obtainable that the mucous and spastic "colitis" preceded the onset of the nonspecific ulcerative colitis, sometimes by many years, indicating strongly that the ulcerative lesions are usually the late manifestation of the functional colonic disorders That increased tone and peristals of both small and large intestine are exceedingly common in Graves' syndrome is a well attested roentgenologic observation 32 Clinical observation also confirms the precedence of Graves' syndrome to colonic disorders and not vice versa It is safe to conclude that the personality changes in Graves' syndrome may predispose to a colonic disorder and that the personality of the latter is entirely passive in the reverse direction When both occur together, they may be simultaneous reactions, so that in such instances there is an overlapping of personalities

Graves' Syndrome and Cardiospasm—No instance of this association was encountered, so that apparently the two personalities do not overlap

Peptic Ulcer and Colonic Disorders —Of a total of 603 cases the association of these two maladies occurred in 126 per cent. It is of particular significance that all these colonic disorders were represented in the form of spastic or mucous "colitis". Not a single instance of nonspecific ulcerative colitis was encountered. This may be interpreted in one of two ways.

1 The functional lesion had not fully matured, and a larger series or a more prolonged follow-up would have revealed one or more cases of an associated nonspecific ulcerative colitis. We cannot exclude this possibility

2 The personality changes in spastic and mucous "colitis" on the one hand, and those of nonspecific ulcerative colitis on the other, vary in intensity of expression

We are inclined to take the latter view, since we have already observed that in the fully developed types of nonspecific ulcerative colitis, the personality type is the direct antithesis of that of the peptic ulcer. The peptic ulcer is the sadistic, aggressive, forceful, go-getting, all-or-nothing individual. In nonspecific ulcerative colitis, he is submissive, dependent, weak-willed, and a defeatist at heart. His aggresion does not lead to attempts to dominate a person or a situation as in peptic ulcer but is a dependent on a negativistic aggression.

We conclude, therefore, that while there is a certain overlapping between the personalities of

peptic ulcer and the minor forms of colonic disorders, there is a direct antithesis between the personalities of peptic ulcer and nonspecific ulcerative colitis

Peptic Ulcer and Cardiospasm —Of a total of 203 cases of peptic ulcer, cardiospasm occurred in 9 5 per cent. In every instance, the peptic ulcer preceded the cardiospasm by a number of years. On questioning, such patients admitted that the cardiospasm arose entirely from fear that the ingestion of food would cause distress. From this it is evident that the ulcer works as an activating agent. For this reason, as we remarked before, we do not regard primary and secondary cardiospasm as distinctive disease entities.

Cardiospasm with Hypertension —Of 42 cases of cardiospasm, an associated hypertension was present in one case, an incidence of 24 per cent. In this case, the hypertension occurred in an elderly individual and was of long standing, while the onset of the cardiospasm had occurred only five months previously. In this instance, the cardiospasm arose from influences entirely unconnected with his hypertension.

Cardiospasm and Graves' Syndrome —Of a total of 416 cases of both disorders, the association of the two maladies occurred in two instances, or approximately 0.5 per cent—In one case, the two disorders appeared almost simultaneously, in the second, the cardiospasm preceded the Graves' syndrome by seven years—The cases are too few to permit any deduction

Cardiospasm and Colonic Disorders —There was not a single association in our collected series

Summary

A study was made to note the frequency of association of psychosomatic disorders in the same individual. The following psychosomatic disorders were selected essential hypertension, Graves' syndrome, peptic ulcer, colonic disorders, including mucous "colitis," spastic "colitis" and nonspecific ulcerative colitis, and cardiospasm

We submitted the thesis that in the production of psychosomatic disorders the following biologic sequence may be constructed

Constitution times psychologic trauma gives hyperkinesis which results in psychosomatic disease

We believe that the variety of psychosomatic disease which will be engendered is related to the type personality and not to the specific kind of psychologic trauma

The type personality coincident with these various psychosomatic diseases is described. In the description of these types a considerable overlapping is noted, accounting for the association of certain psychosomatic disorders in the same indi-

vidual This accounts for the not infrequent association of hypertension and peptic ulcer and Graves' syndrome and colonic disorders On the other hand, the invariable precedence of one psychosomatic disorder to the other is a strong indication that the first disorder acts as an activating agent This applies to the sequential rela tion of essential hypertension to Graves' syn drome, of pentic ulcer to Graves' syndrome, and of cardiospasm to peptie ulcer

No instance of the association of peptic ulcer and nonspecific ulcerative colitis was noted in our senes, and we believe this is due to the fact that the personalities of the two diseases are antithetic

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ULCER PATIENTS NEED REST

Complete physical rest for patients with stomach ulcers gots strong support from research by Dr C W Lillehei National Cancer trainee and Dr O H. Wangensteen, professor of surgery at the University of Minnesota Medical School at Minnespolis.

Moderately severe physical activity from fairly stremuous exercise they find, helps bring on a certain type of ulcers in dogs.

The ulcers are the kind that come following injections of histamine, a body chemical which stimulates stomach activity and dilates amali blood vessels.

Histamine provoked ulcers about three times as often in dogs tired by strenuous muscular activity as in dogs that were not doing tiring exercise the scientasts report to the January Society for Experimental Biology and Medicine.

Strangely however muscular fatigue decreased the output of hydrochloric acid in the dogs' stomachs. By decreasing the acid output it might seem that muscular fatigue would decrease instead of increase ulcer formation The apparent paradox, the scientists explain suggests that muscular fatigue affects the stomach lining itself and makes it more vulnerable to the action of the acid-pepsin mixture in the atomach julces.

Strongous muscular exercise probably affects the stomach lming by changing its blood circulation The exercise would cause blood to be diverted from

the stomach lining to the leg muscles Constricting the blood vessels, so that less blood gots to the stomach lining, aids and abets ulcer for mation the scientists found in another experiment The blood vessel construction in this case was brought about by injections of adrenalin. This fits in with the muscular fatigue findings because muscular fa tique is known to cause liberation of adrenalin in the

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Science News Letter April 17, 1948

THE ELECTROCARDIOGRAM IN INFECTIOUS MONONUCLEOSIS

 $Harry\;L\;\;Jaffe,\;M\;D$, Leonard E $\;Field,\;M\;D$, and $Arthur\;M\;\;Master,\;M\;D$, New York City

(From the Cardiographic Laboratory, Mount Sinai Hospital)

A NUMBER of years ago Master and Jaffe called attention to the transient, nonspecific changes that appear in the electrocardiogram during certain acute infections and vascular diseases ¹² Since that time similar electrocardiographic abnormalities have been reported in an ever-increasing number of infectious diseases. One of the latest of these is infectious mononucleosis, during which alterations in the T-waves and in the P-R interval have been observed ³⁻⁵ In a recent analysis of the electrocardiograms in a series of cases of acute infections, it was found that a relatively large percentage of patients with infectious mononucleosis had electrocardiographic abnormalities ⁶

The present report is a review of 22 cases of infectious mononucleosis in which electrocardiograms had been recorded. These cases were selected from a group of 50 consecutive patients with this disease, in the remaining cases no tracings had been made. The patients presented the various clinical symptoms and signs usually encountered in this disease. In all instances the diagnosis was confirmed by finding characteristic cells in the blood or the bone marrow, by a positive heterophil reaction, or by both

Electrocardiographic Findings

One or more electrocardiograms were taken in the 22 cases, employing the three standard limb leads and CF₄ or multiple CF leads. Significant deviations from normal were present in nine cases, or 41 per cent (Table 1). The tracings were normal in ten cases, minor changes within the normal range of variation occurred in three cases. In most of the cases in which the electrocardiograms were normal only one record was made. Serial tracings would probably have revealed abnormalities among this group.

Lowering or inversion of the T-waves was the characteristic deviation in nine abnormal electrocardiograms. Two of these also showed changes in the P-R interval. In one instance the

P-R interval was prolonged to 0.24 second, in the other the P-R interval varied from 0.20 to 0.16 second in serial records, without appreciable alteration in the rate of the heart. Significant Q-waves, QRS abnormalities, or RS-T deviations were not found. In several of the electrocardiograms of the remainder of the group the RS-T segments were slightly elevated, but, as these deviations persisted, importance was not attached to them

The T-wave alterations appeared in both the limb and the chest leads in three cases, in the chest leads alone in two cases, and in the limb leads alone in four cases. The degree of T-wave inversion was moderate in eight cases, in one, T_2 and T_3 became deeply inverted (Fig. 1)

Occasional auricular premature contractions occurred in one case Ventricular premature beats and other arrhythmias observed by several authors did not appear among our patients ⁵ ⁷

In the cases with abnormal electrocardiograms the deviations were noted in the initial tracing made within forty-eight hours following hospitalization. However, since the patients had been ill for days or weeks prior to admission, correlation with the day of onset of symptoms of infectious mononucleosis disclosed that the electrocardiogram may be abnormal as early as the fifth day of illness. In several instances the record returned to normal within ten days. Four patients exhibited the abnormalities for three to four weeks.

Clinical Correlation of the Electrocardiogram

We were unable to detect a correlation between the electrocardiographic deviations and the clinical and laboratory findings. Active carditis was not noted in any of the patients. A pericardial rub was not heard at any time. Soft systolic murmurs audible over the aortic area in two cases and over the apex in another were believed to be "functional" in origin. In one instance a

TABLE 1 -ECG FINDINGS IN INFECTIOUS MONONUCLEOSIS (FIGS 1-6)

Case	Sex	Age	Ti	T2	Tı	T.	P-R Interval
M V J P	M	15	Low	Inverted	Inverted		
D M	Ň	28 17	Low	Diphasic	Low	Inverted Semi inverted	
M P S D	F	12 4 ¹ /2	Low	Low	Inverted	Inverted	
$\bar{\mathbf{P}}$ $\bar{\mathbf{L}}$	M	31	Low Low	Low Low	Semi inverted	Notched	0 24 to 0 17 second
AK SB	ь УІ	17 43	Low	Isoelectric	Diphasic	Diphasic	
ŠF	M	24		Low	Inverted	Diphasic	0 20 to 0 10 second

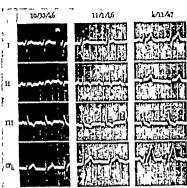


Fig. 1 M V—October 30 1946 T₁ low T₂ diphasic T₁ inverted November 1, 1940 T₂ now inverted April 1 1947 Normal ECG T₁, taller T₂ upright

systolic murmur heard over both the apex and the base may have represented chronic rhou matic valvular disease although evidence of an active rheumatic condition was lacking

The highest temperature ranged between 102 and 104 F, the duration of fever being between five and thirty days. The leukocyte count varied from 3,800 to 20 900. The percentage of atypical lymphoid cells, from a few to 23 per cent. In two cases the heterophil reaction was only 1.8 in the others it was positive once reaching the very high titer of 1.32 768. Jaundice was present in one patient.

The clinical course in all instances was mild or moderately severe. The patient whose electrocardiogram showed the most pronounced in version of the T waves ran a very benign course.

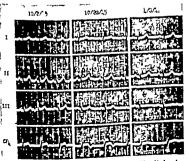


Fig. 2. J. P.—October 2 1945 T. diphasic October 20 1945 T. lower T. inverted April 8, 1947 Normal ECG T. taller T. upright.

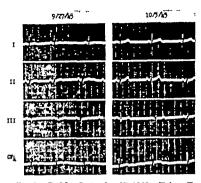


Fig. 3 D M —September 27 1045 T₁ low T₂ diphasic, T₂ low, T₄ semi-inverted October 3 1045 Normal ECG T_{1-2, 2} taller T₄ upright

Comment

As with other acute infectious diseases, non specific alterations may occur in the electrocardiogram of patients with infectious mononucleosis. Abnormalities have been observed most frequently in the T-waves—Occasionally there is disturbance in auriculoveratricular conduction and depression of the RS-T segment as well as minor arrhythmias. These observations again illustrate the futility of attempting to make an etiologic diagnosis as for instance rheumatic fever, solely on the basis of such nonspecific changes in the electrocardiogram.

Longcope included in his series of cases of in fectious mononucleosis a putient whose electrocardiogram showed ventricular premature contractions and 'T inverted ' The lead in which the T wave was inverted was not mentioned Logue and Hanson in an article on partial heart block listed one case of infectious mononucleosis

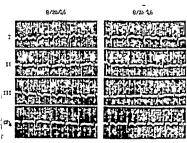


Fig. 4 M. P.—August 20 1046 T₂ low T₃ inverted T₄ low August 28 1046 T₁ lower T₃ low T₄ less inverted T₄ inverted.

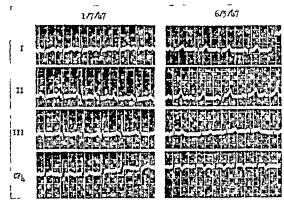


Fig 5 S D — January 7, 1947 T₁ 2 low, T semi-inverted, T₄ notched, June 3, 1947 Norma ECG, T₁ 2 taller, T₄ inverted

with a prolonged P-R interval 8 Candel and Wheelock presented eleven cases of acute infections with electrocardiographic changes 9 Among these was a case of infectious mononucleosis with minor T-wave alterations in the chest lead Evans and Graybiel reported four cases of infectious mononucleosis with T-wave changes consisting primarily of lowering of the T-waves and, in one instance, inversion of T. 1 These abnormalities persisted from six to forty-one days The authors considered the T-wave changes, at least in their first case, to be the result of pericardial involvement, because they persisted "over a longer period of time than would be expected if the myocardium alone were affected "Young included two patients with infectious mononucleosis in a series of 13 cases of upper respiratory infections in which electrocardiographic changes occurred 10 In one case the P-R interval varied between 0 16 and 0 20 seconds, and in the other the T-waves varied in height

Wechsler, Rosenblum, and Sills compiled the largest group of abnormal electrocardiograms in this disease during an epidemic at an Army post ⁵ Of 223 patients, 45 cases showed T-wave changes, and 14 showed prolonged P-R interval with or without T-wave alteration. The largest P-R interval noted was 0.40 second. There were two instances of transient second degree heart block.

In a wide variety of bacterial, parasitic, and virus diseases electrocardiographic changes can be correlated with the findings of acute myocarditis anatomically, even though clinical signs and symptoms are frequently absent or minimal ⁶ In infectious mononucleosis, as in upper respiratory infections in general, the interpretation of the T-wave changes is rendered difficult by the benign course of the disease, the absence of cardiac signs, and the paucity of postmortem material

Recent reviews of many hundreds of cases of

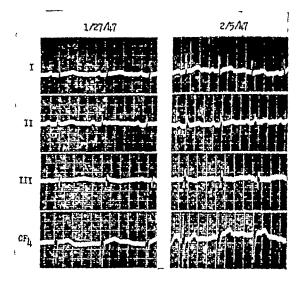


Fig 6 P L—January 27, 1947 T₁ low, T₂ low, P-R interval 0 24 second, February 5, 1947 T₁ 2 taller, P-R interval 0 18 second

infectious mononucleosis report that cardiac symptoms were not found in any patient 11-17 However, Wintrobe mentions a patient in whom "tachycardia and cyanosis became so pronounced as to suggest acute cardiac dilatation "18 Bradshaw reports a case in which signs of mitral stenosis and congestive heart failure developed six weeks following recovery from infectious mononucleosis 19 However, the sequence of events in this case is open to question. In one of the cases of Evans and Graybiel a pericardial friction rub was heard, and in another there was slight cardiac enlargement which subsequently disappeared 4 In a fifth case, not included in their group of patients with abnormal electrocardiograms, pericarditis with effusion developed without evidence of rheumatic fever. In the large series of Wechsler, Rosenblum, and Sills, an occasional patient complained of intermittent, sharp, precordial pain 5 Except for a greater tendency to relapse, there were no other significant differences between those with abnormal and normal electrocardiograms Only one instance of unexplained cardiac enlargement was noted authors also found that, following defervescence, bradycardia and sinus arrhythmia obtained for at least as long as the electrocardiograms were abnormal This, together with a peculiar waving and waning of T₁ for sixth months or more, led these authors to consider the underlying mechanism to be either autonomic imbalance or possible myocardial involvement

Only recently has autopsy evidence of the existence of myocarditis in infectious mononucleosis been made available. Ziegler describes the case of a twenty-two-year-old girl whose "heart

muscle appeared remarkably free of cellular in filtrations. It showed the acute changes common to many infectious diseases "20 Allen and Kellner report the necropsy findings in a twentythree-year-old soldier who was killed accidentally two weeks following cossation of symptoms of infertious mononucleous 21 The patient had been only moderately ill, and clinical signs of cardine involvement had been absent Focal interstitial infiltrations composed of mononuclear cells and lymphocytes were found. The collections of cells were small to moderate in size There was no muscle atrophy or replacement of muscle fibers In two fatal cases of infectious mononucleosis with involvement of the central nervous system and the Guillain Barré syndrome, the hearts were essentially normal except for scattered subemeardial petechine, indistinct cross strictions, and occasional, small, perivascular collections of lymphocytes in the epicardium of the left ventri cle.22 Brien mentions two fatal cases in which there were present "small accumulations of mononucleosis cells in the muscle and under the endocardum."23 Very recently, Gore and Saphir listed nine fatal cases, six of which showed myocarditis lustologically 24

It has been suggested that infectious mononucleosis is a virus disease, but this is still uncertain It is known that myocarditis may develop not only during the course of bacterial infections but also during such virus diseases as influenza A, poliomyelitis, and mumps.24-27 Myocardial anovemia may play a role in the development of the Virus pericarditis has also been delesions 25 sembed 23

Since it is evident that true my ocarditis may occur in infectious mononucleosis, electrocardiographic changes should not be disregarded or considered lightly Despite the absence of climcal signs and symptoms referable to the heart, the high proportion of abnormal electrocardiograms that occurred in our group of cases indicates that it is advisable to take tracings routinely If abnormalities are found the patient's activities should be restricted, and the period of convalescence should be extended until the record returns to normal or remains stationary in the unusual cases in which the changes persist

Proper evaluation of the T wave changes is important. In some of the cases mentioned in the literature slight lowering of the T wave in one lead is the only deviation reported to In view of the fact that minor alterations in the Twave may be caused by such factors as fever, increased tonus of the autonomic nervous system, tachycardia, acid-base disturbances, and the poation of the patient only well-defined alterations

should be considered indicative of myocardial involvement.

Summary

Pronounced deviations in the T-wave were present in nine of 22 cases (41 per cent) of infectious mononucleosis In addition to the T-wave changes, the P-R interval was prolonged in two of the cases

These changes were probably the result of or canic changes in the myocardium although clini cal signs of acute myocarditis rarely occur in in fectious mononucleosis

Whenever possible, an electrocardiogram should be recorded routinely in this disease When abnormalities are present, the period of convalescence should be extended until the tracings become normal

The electrocardiographic alterations in infec tious mononucleosis are nonspecific and similar to those that occur in numerous other acute infectious diseases.

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THE NITROFURANS

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FOLLOWING the discovery of the sulfonamides, a marked stimulation in basic research to find other effective chemotherapeutic agents became evident In 1944, Dodd and Stillman, reviewing the literature, noted that several investigators had found the furan group of compounds to be bacteriostatic 1 Following this lead, they prepared 42 furan compounds and screened them against Staphylococcus aureus, Streptococcus hemolyticus (S pyogenes), Diplococcus pneumoniae Type 1, Eberthella typhosa, Escherichia coli, and Pseudomonas aeruginosa They found the nitro group was (P pyocyanea) essential in activating these furan compounds to produce effective bacteriostasis They also noted that some of the nitrofurans were bactericidal as well as bacteriostatic, this fact being determined by the concentration of the drug compounds that were selected from the initial 42 were definitely bacteriostatic against at least five of the six test organisms which included both gram-positive and gram-negative bacteria

Cramer and Dodd investigated the mode of action of the nitrofurans using Staphylococcus aureus as the test organism 2 They selected the six most promising compounds from the Dodd-Stillman investigation Of these six, one compound, nitrofurazone N N R, 5-nitro-2-furaldehyde semicarbazone (Furacin), was found to have an unusual mode of bacteriostatic action showed marked activity during the lag phase of growth, prolonging the time of the phase During this lag phase no reproduction takes place, and it is thought to be normally a period of intense vital activity of the organism time it was not known whether Furacin affected any vital process other than reproduction so that the time of maturation was prolonged, or whether it interfered directly with cell division

A more recent publication by Cramer discusses the mode of action of Furacin on bacteria ³ This is a very technical article based on the application of physiochemical methods to the study of the action of Furacin against Staphylococcus aureus He concludes that a chemical reaction takes place, during which Furacin is reduced. As a result of this reduction, the enzyme system necessary to the growth of the bacterium is temporarily mactivated, and thus, the so-called "lag phase" of the organism is prolonged. This results in a

Presented at the 41st Annual Meeting of the Sixth District Branch of the Medical Society of the State of New York Norwich New York October 15 1947 period of relative inactivity in the life cycle of the organism

It may be inferred from the above that during the so-called "lag phase" the normal antibacterial mechanisms of the host could take over and eliminate the invading organisms

Furacin is a lemon-yellow, crystalline substance. It is stable at 15 pounds pressure for at least fifteen minutes in the autoclave but decomposes above a temperature of 227 C. It is slightly soluble in water (1 4,200) and soluble in Carbowax (polyethylene glycol, 1 100). Upon exposure to light and certain metals it is discolored but still retains its antibacterial efficiency.

In 1945, Krantz and Evans investigated Furacin pharmacologically 4 They found the drug to have no toxic effect on blood pressure, respiration, or cardiac action when administered to dogs in relatively large doses In vitro tests indicated no effect on the cytochrome ovidase system ever, there was definite retardation of tissue dehydrogenase activity by the drug in vitro acute toxicity tests the LD to for rats was found to be 590 mg per Kg, and 380 mg per Kg for mice Chronic toxicity tests in monkeys, who received orally 0 3 Gm daily for five weeks, produced no significant pathologic effects. In rats, 0.4 per cent Furacin in the diet caused death tologic sections showed congulated albuminous fluid in kidney tubules and small focal necrotic areas in the livers

After the animal experiments, these investigators ran several preliminary tests in man. One of them (Evans) took 100 mg of the drug orally with no demonstrable symptoms. One hundred mg were then given to each of several other persons three times a day. Finally the dose was increased to 3 or 4 Gm daily. This dose was well tolerated in 80 per cent of the test subjects. Twenty per cent, however, experienced nausea. Results of routine blood and urine tests were normal.

The conclusions drawn from this pharmacologic study were that relatively large doses were non-toxic to animals. Toxic doses in animals produced hyperexcitability of the central nervous system. Preliminary oral ingestion of the drug by man seemed to indicate low toxicity. The animal work has continued under Carr, and preliminary reports indicate that 0.1 Gm a day has been ingested by dogs and monkeys for a period of over five months with no evidence of toxicity.

In 1946, Dodd investigated the chemothera-

peutic properties of Furacin in vitro and in vivo and found definite beneficial effects in the treat ment of both bacterial and trypanosomal systemic infections in mice by oral subcutaneous, or intramuscular administration of the drug. He showed in vitro that the drug had a wide antibacterial spectrum against many gram positive and gram negative organisms. He also noted that, while the nutro group conferred antibacterial activity in vitro the only compounds effective in vivo were those nitrofurans closely related to the semicarbazone compounds

Dodd confirmed Krantz and Evans' findings that the toxic doses in rats and mice produced hypermitability, tremors, convulsions, and respiratory failure, indicating a toxic effect on the central nervous system He found the LD in mice to be 545 to 587 mg per Kg Histologic studies showed no pathologic changes to account for the symptoms produced by oral administra tion, but severe toxic hepatitis and extensive degeneration of the renal tubules were found after massive subcutaneous doses The in vivo studies indicated that Furacin was effective orally in mice infected with Staphylococcus aureus Streptococcus pyogenes (hemolytic) Salmonella schottmuellen, and Salmonella aertrycke It was not effective against the pneumococcus verity of the infection had a definite effect on the survivals capecially in the gram negative species It was very effective in the treatment of Try panosoma equiperdum infections protecting 100 per cent of the rate against a 100 per cent fatal dose of organisms when 100 mg per Kg of the drug was administered orally

Preliminary experiments indicated activity against Treponema pallidum in vitro and in vito in infected rabbits. This preliminary work has been confirmed recently by another investigator and the work is being continued to ascertain whether or not permanent clinical and scrologic

cure is possible 7

A recent report by Green and Mudd indicates that when several gram-positive and gram-nega tive bacteria (Staphylococcus aureus Escherichia coli Proteus vulgans, Streptococcus viridans Staphylococcus albus and Shigella paradysen teriae) were made resistant by repeated cultures in increasing concentrations of three other drugs Le, sulfathiazole, streptomycin and penicillin or obtained from patients being treated with these drugs they were still as susceptible to Furacin as the original nonresistant organisms. In other words no cross resistance to Furacin develops in vitro as the result of repeated exposures of the selected organisms to sulfathuasole streptomycin, and penicillin The advantage of this factor is opvious

In July of 1946 Dodd Hartmann, and Ward

reported on the effects of several nitrofurans on the healing time of experimental wounds in rabbits. They concluded that two of these compounds were nonirritating, nontoxic, and had no adverse effects on healing. One of these compounds was Furacin.

Noter and Lamberti in August of 1946 reported that Furacin had proved effective in the treatment of infected wounds in rabbits. These wounds were artificially made and infected with both hemolytic streptococcus. They concluded that further clinical work was definitely indicated

The discussion so far has dealt with the original elemistry, pharmacology, and bacteriologic work with the compound. A review of the literature covering the use of Furacin in the clinic is now in order.

Clinical Use of Furacin

The first clinical results reported were by Snyder Kiehn and Christopherson on chronically infected war wounds in November 1945 ¹¹. They made cultures from the wounds and determined the bacterial flora and also checked the effectiveness of Furnein against the bacterial present in the wounds by cultures on blood agar. The wounds were treated by application of Furnein Soluble Dressing They were redressed and subsequent cultures usually taken each day thereafter. The series was small, consisting of ten patients. However, it was very well controlled

Snyder and his coworkers noted that clinical improvement in all cases was directly correlated with a quantitative and qualitative reduction in the bacterial flora especially of gram-positive organisms as demonstrated by repeated cultures. They concluded that the compound was highly effective in vivo in the control of surface infections.

The next report of interest was by Meleney and his coworkers in January, 1946 it. They were particularly interested in finding antibacterial agents effective against gram negative organisms not susceptible to penicillin. Only five compounds met their stringent requirements. One of these was streptomyen and another was Furacin. They found that Furacin was effective against many of the gram negative organisms with the exception of Pseudomonas aeruginosa (P. pyocy anea).

The next clinical investigation was by McCol lough and summarized his findings in the treatment of infected war wounds. ¹² He treated 94 chronically infected wounds, 37 cases were healed completely, and 45 cases showed improvement

Daily cultures were made, and it was noted that Staphylococcus aureus and Streptococcus pyogenes usually disappeared shortly after ther any was instituted The gram-negative organ-18ms were present longer than the gram-positive organisms despite the fact that the wounds were obviously healing A total of 597 cultures was made, and 97 of these were negative immediately after treatment was instituted $T\pi$ elve of the wounds had been indolent with no change in size or amount of drainage for an average of fifty They healed in an average of twenty-one days after Furacin therapy was begun were four cases of sensitivity to the drug evidenced by local vesicular eruption and erythema All cleared within one week after the drug was These four patients gave a posidiscontinued tive patch test to Furncin This was the first

clinical observation of sensitivity to Furacin

The first report in the field of dermatology was made by Downing, Hanson, and Lamb in February, 1947 14 Two hundred twelve patients Meleney's classification was used were treated in appraising the results. In the summary of Downing's paper, it was noted that the drug did not interfere with normal granulation and epithelization of infected ulcers. There was no clinical evidence of toxicity due to absorption of the drug even when used in large amounts over prolonged periods of time. This was further confirmed by necropsy of three of the patients who died from other causes two of diabetes and one of a cerebrovascular accident From the bacterial cultures it was evident that a large percentage of the infecting organisms, both grampositive and gram-negative, was controlled by the drug

cutaneous diseases due to lower organisms and also in infected ulcers It showed excellent results in the superficial infections such as impetigo and ecthyma

Furacin was found effective in the treatment of

A note of warning was sounded in respect to sensitization At the same time it was noted that the sensitivity factor was less than that of the sulfonamides and penicillin when used locally A recent communication by Downing to this author indicates a sensitization rate of approxi-This corresponds to the avermately 4 per cent age incidence reported in the literature to date

Shipley and Dodd reported the clinical and bacteriologic results obtained in the treatment of 90 cases with superficial infections 15 The results in 26 cases were reported as brilliant, in 44 cases as good, the results in the remaining 20 cases were either questionable or negative tention was called to the fact that the use of Furacin was no substitute for surgical intervention In six skin graft cases the graft when indicated

was applied to the recipient area that had been treated with Furacin, and no attempt was made to remove the drug before the graft was applied

The majority of the grafts were successful When deep-seated abscesses were incised and drained and then packed with the medication. healing time was shortened. The decrease in amount of discharge and odor was very notice-Fifteen vascular ulcers of the leg responded

rapidly in so far as the infection was concerned They granulated well, and no retardation of epithelization was evident

In several cases the dressing was used to prevent an anticipated infection in surgical proce-Two patients had a Torek operation The scrotal-thigh incision was covered with the Furacin Soluble Dressing, and no slough or infection occurred Two patients had a Mikulicz colostomy through an inguinal incision wounds healed by early granulation despite the presence of fecal material. In treating these cases, three facts were particularly noted the effect on the base of the ulcers, the amount of dis-In the majority, the infection charge, and odor disappeared almost at once, leaving a clean granulating base with no retardation of epithelization The wound discharge decreased appreciably within twenty-four to forty-eight hours The odor decreased within twenty-four hours and was

closely connected with diminution of bacterial

after forty-four days' treatment, the other after

eight days A fine, red, papular rash developed

eight hours after treatment was discontinued

locally

Two cases of sensitivity were noted, one

The erythema disappeared within forty-

The bacteriologic studies were quite complete. Proteus vulgaris, Pseudomonas aeruginosa, Bacillus pyocyaneus, and Aerobacter aerogenes were the most common gram-negative organisms Sixty-three per cent of the cultures became negative during the treatment in times varying from twenty-four hours to thirty days Resistance of the gram-negative species was greater than the gram-positive group The occurrence of the

various organisms is shown in Table 1 Clinical and in vitro results with Pseudomonas aerugmosa (Bacillus pyocyaneus) showed the orgamsm to be definitely susceptible to Furacin This finding was not in agreement with previous

0	Percentage of	Incidence in
Organism	Cases T	reated
Gram negative		
Proteus vulgaris	40	
Bacillus pyocyaneus	37	5
Escherichia coli	33	5
Aerobacter aerogenes	25	•
Gram positive	20	
Diphtheroids	37	5
Staphylococous albus	12	
Streptococcus pyogenes		•
(hemolytic)	7	1
Staphylococcus aureus	6	6
Streptococcus anhemolyticus	ŏ	·

reports. The possibility of symbiosis being responsible was considered

A recent publication by Robinson and Robin son confirms the effectiveness of Furacin in the field of dermatology 16 They treated 171 pa tients with the following drugs incorporated in omitments penicillin, tyrothricin Furacin ammomated mercury, and boric acid Occlusive dressings were applied daily under direct super vision to 50 patients with daily cultures being made of the lesions It was found that Staphylococcus albus and S aureus, and Streptococcus progenes (hemolytic) were the most common causative organisms. The remaining 121 pa tients used the medication themselves at home and were checked at weekly intervals Ecthyma and impetigo contagiosa comprised 167 of the cases. Satisfactory results were obtained with all the preparations used and varied only in length of time necessary for healing noted that the applications of penicillin and Fura on ointments caused healing in somewhat fewer average days than the other agents due to sensitivity were noted in three of 17 pa tients using tyrothricin with ammoniated mer cury in one out of 68, with Furacin in two out of 37, with penicillin in one out of 29 and with boric acid in none of 20 patients

Miller and his coworkers have recently reported good results with Furaein Soluble Dressing in 16 of 18 cases of impetigo, with times of cure aver aging eight days."

This summarizes the publications on Furacin to date A discussion of reports on the present use and results in the various specialities is now in

Specialty Uses of Furacin

Surgery —Many new uses of Furacun have been reported in the surgical specialties. In thoracoplasty for pulmonary tuberculous the operative wound and occasional resulting sinus are being packed with Furacin impregnated gauge. The pack is replaced frequently and granulation and healing times of these types of wounds have been significantly shorter than the controls. Also, in the field of thoracic surgery, injections of 50 to 100 cc of Furacin Solution into the pleural cavity in secondarily infected tuber culous empyemias have greatly facilitated subsequent closed drainage of the cavities.

In plastic surgery it is routine to prepare the imany cases the graft is applied without removing the remaining Furacin is It is also routine to treat the donor site prophylactically. In a series of over 100 cases use of Furacin Soluble Dressing has cut down the time necessary to prepare the infected recipient site from a provious average of

seventeen to twenty three days to nine to thirteen days in most cases. This is approximately a 40 per cent decrease in the time required

Proctology —Furnon Soluble Dressing is being used preoperatively in pilonidal cysts and before hemorrhoidectomy to decrease infection ¹¹ It is also used routinely as postoperative treatment in these cases and in rectal fistulas —A suppository is now being prepared to handle this problem more effectively

Cynecology and Obstetrics—Furacin Soluble Dressing is being used on vaginal tampons for the local treatment of cervicitis, following cauterization and after operative repairs. A vaginal suppository and cream containing Furacin are now being evaluated in the clinic to determine if they are more satisfactory than the tampon method of application.

Urology—Instillation of Furacin Solution in cystics, either full strength or diluted with sterile distilled water, has been reported to be effective 12

Orthopedics — Use of Furnam Soluble Dressing as a packing in osteomyellitis has been reported, but results are controversial and more work is necessary before any conclusions can be reached

Otology —Furacin Solution has been used rather extensively in the treatment of otits externa and otits media. One series was conducted at a training school for mentally deficient children. The medical staff had had great difficulty with chronic otits media in these children. The condition had been present for years in some of the patients. Over a period of six months 19 patients were treated of which 17 had a true otitis media with a perforated membrane and discharge. Two others had an external otitis. The age of the patients varied from eight to twenty one years.

The results were as follows three of the pa tients were markedly improved with no drainage for three four and five months, respectively The other 16 had symptomatic relief, i.e., decrease in amount of discharge and cossition of foul odor In the three cases that were markedly improved. one had a staphylococcic infection in another there was no culture obtainable, and in the third Proteus organisms were isolated — In the first two cases the ears were dry In the third moisture was still present behind the tympanic membrane Of the total of 19 patients, one showed a local sensitivity to the drug, manifested by a weeping red, swollen external canal This is in agreement with the general consensus of opinion that approximately 4 per cent of patients will be sensitized to Furacia used over prolonged periods

There have been other favorable reports from otologats. One physician has used it in several cases of otitis externa and otitis media with good results. He recently had a case of otitis externa

due to Pseudomonas aeruginosa (B. pyocyaneus) which responded very satisfactorily A number of other preparations had been tried on this patient without effect Another report indicates it to be fairly effective in the treatment of Proteus Furacin Soluble Dressing has been used with some success in chronically discharging mastoidectomy cases In another series of 12 cases of otitis treated with Furacia, good results The bacterial flora were obtained in ten cases were mostly Proteus, Pseudomonas, and Diphtheroids, and two of the cases treated were heavily infected with hemolytic Staphylococcus albus

Rhinology —Furacin Solution has been used to treat an extensive osteomyelitis involving the hard palate, the lateral and posterior wall of the antrums, and the turbinate bones, following a septal operation 18 Penicillin, sulfonamides, and tyrothricin were of no value Irrigation of the sinuses and subsequent instillation of Furacin Solution every three hours caused a prompt fall in the temperature and greatly lessened the discharge and eliminated the foul odor case the symptoms were due largely to Proteus, although cultures showed Staphylococcus, Streptococcus, and Proteus Furacin Soluble Dressing has also been used in packing an open osteomyelitis of the frontal sinus

Ophthalmology —Furacin Soluble Dressing is being used in the treatment of corneal burns It has also been used for conjunctivitis and blepharitis of bacterial origin and following drainage of infected meibomian glands When the drug is used around the eye, the possibility of sensitization after prolonged use should be borne in mind

Systemic Use of Furacin —Furacin was administered orally to 84 patients by Shipley and Dodd to determine tolerance, dosage, and therapeutic effectiveness 20 The dosage varied from 1 to 6 Gm daily Nausea with occasional vomiting was the most common untoward reaction sitization and peripheral neuritis occurred in one Routine laboratory studies were nor-Excellent results were obtained in two cases of acute typhoid fever, also, seven cases of cystitis and three of pyelitis all infected with Escherichia coli showed remarkable improvement Five of seven cases of gonorrheal salpingitis responded rapidly to treatment The two cases which did not respond showed large pelvic abscesses when a laparotomy was performed review of these cases, it was noted that the gramnegative organisms, especially Escherichia coli and Eberthella typhosa, are particularly sensitive It also appears that the drug is most effective in infections involving the gastrointestinal and genitourinary tracts The results warrant further clinical evaluation

Future Possibilities

It was previously mentioned that Furacin was active against the organism Trypanosoma equip-Sleeping sickness is caused by an organism of this group The problem is now being thoroughly investigated at the University of Texas where facilities are available for intensive study of this organism Also, the possibility that the drug may be active against the Mycobacterium tuberculosis, either alone or in conjunction with streptomycin, is to be investigated by the laboratory at the Trudeau Foundation

This paper has dealt primarily with Furacin (5-nitro-2-furaldehyde semicarbazone) ran series contains many other compounds besides Several of these compounds synthesized recently have given evidence of pharmacologic activity, and one has shown a pronounced antihistaminie effect with a smaller dosage and lower toxicity than any other drugs of this type now available Another compound exhibits definite sympathomimetric effects

These compounds have been mentioned to indicate the varied potential therapeutic value that may be hidden in the furan group of compounds which seem to have been neglected in the frantic search for newer and better chemotherapeutic agents

Summary

This paper summarizes the history of the nitro-It touches briefly on their chemistry. pharmacology, and bacteriology

The significant results of clinical investigations. as reported to date, are discussed mention is made of future possibilities of furans

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COCCIDIOIDOMY COSIS IN VETERANS OF WORLD WAR II

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JUMAN infection with the fungus Coccidioi I des immitis occurs in the United States principally in endemic areas in southern Cali forms western Texas, Arizona, New Mexico and probably also in southern Utah These localities have been designated as true endemic areas because of the occurrence of outbreaks of this disease, the results of skin testing with coccidiodin recovery of the fungus from the soil, or the presence of the infection in autopsied desert animala 1 2

Sporadic cases have been reported from other rections of the country Usually such cases have given a history of residence in one of the endemic areas Occasionally it has been difficult to determine the mode of infection especially when the patient gave no history of travel in an endemic region. In such cases infection has been assumed to occur by unusual means *

As a result of World War II however cocci dioidal infection can no longer be considered a duease confined to the southwestern or western United States Increase in travel facilities shift ing populations, and exposure of soldiers in training areas in the endemic belt have resulted in the discovery of cases of coccidioidomycosis far from their original geographic site of infection

Two such cases are herein presented in which the primary infection occurred while in Army service in an endemic area. The diagnosis of cocciliondomycosis was not made for some time however after their return to civilian activities in New York City

Case Reports

Case 1—(Residual pulmonary coccidoidal infil tration resembling tuberculosis.) The patient was a woman who was discharged from the Army in Janu ary 1946 In January 1947 a routine chest x-ray was taken as part of a cliest survey of Hunter College students. The roentgenogram revealed an infiltra tion in the left lung The patient was referred to a Health Department clinic where the findings were confirmed and she was advised to enter a tubercu losis sanatorium Sho was subsequently examined at the New York Regional Office of the Veterans Administration. The patient volunteered the in formation that she was a positive reactor to cocci dioidin and suggested that her pulmonary infiltration might be due to coccidioidomycosis questioning elicited the following information

While in the Army she had been stationed in the desert 80 miles north of Tueson Arizona, from May 1943 to February 1945 Routine coccidioidin skin tests were done on all personnel at periodic intervals

She was found to have a positive skin test after six months in the endemic area, but no cliest film was taken. She gave no history of resouratory infection.

at any time during her Army service.

Because of this additional history further studies Tuberculin skin tests with 0 1 mg and 1 mg were negative. A coccidioidin skin test in dilution of 1 1000 was strongly positive after twenty four hours. An x ray taken May 15 1947 showed a nodular infiltration in the peripheral portion of the left infraclavicular region ule measured 1.5 cm in diameter (Fig. 1)

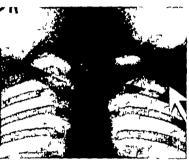


Fig. 1 X ray taken May 15 1947 showing nodular infiltration in the peripheral portion of the left infraclavicular region

lar rounded density was seen in the soft tissue of the hase of the neck on the left side having the appear ance of a cervical gland. Reinspection of the chest x-ray at separation from the Army taken January 18 1946 revealed the identical infiltration in the left The induction v ray taken March 11 lung field 1943 showed no evidence of pulmonary disease

This patient evidently received her primary coccidioidal infection while in the Arizona desert as shown by the positive reaction to coccidioidin after six months residence in that region The nodular infiltrate in the left lung represented an inactive residual lesson of pulmonary coccidioidomycossa. The negative tubercular tests aided in differentiating the pulmonary infiltration from tuberculosis

Case 8 - (Disseminated coccidioidomy costs with pulmonary and skin manifestations.) The patient was a man who had been in the Army in the Cali fornia Arizona desert maneuver area for several months in the spring of 1944 In 1945 about ten months after leaving this region, he developed a skin eruption on the left posterior chest wall with the formation of pink, crythematous, granulomatous plaques. A diagnosis was made of lichen planus

He was hospitalized in November, 1945, at an Army hospital. A routine chest \ray revealed infiltrations in both lungs. He was discharged from the service in November, 1945, with the following diagnosis. Lichen planus, chronic, annular, hypertrophic, and tuberculosis, pulmonary, reinfection type, arrested.

After return to civilian life, he was treated by a private physician for the skin lesions on the posterior chest wall with ultraviolet therapy and injections of bismuth subsalicylate. He was subsequently seen at the New York Regional Office of the Veterans Administration in April, 1947, when he complained of bloody expectoration. Physical examination of the chest was negative. A chest x-ray revealed a nodular and patchy infiltration involving both apices and infraclavicular regions (Fig. 2). A diagnosis



Fig 2 X-ray taken April 3, 1947, showing patchy and nodular infiltration of both upper lung fields

was made of chronic pulmonary tuberculosis, reinfection type Wassermann and Kahn tests were negative

Because of the failure of the skin lesions to respond to therapy, a skin biopsy was done April 30, 1947, and revealed typical findings of coccidioidal granuloma. This was further confirmed by a skin scraping which demonstrated numerous spherules in the wet preparation. Tuberculin skin tests were positive. Coccidioidin skin tests were negative. Reinspection of the chest x-ray taken November 14, 1945, at the time of discharge from the Army, revealed the identical pulmonary infiltrations seen on later films.

This patient undoubtedly received his coccidioidal infection while in the California-Arizona desert Dissemination occurred within ten months, a usual sequence of events. The pulmonary infiltration resembled tuberculosis. The negative skin tests to coccidioidin indicated the development of anergy. Notwithstanding the grave prognosis usually attached to coccidioidal dissemination, this patient appeared in good health and showed no other evidence of coccidioidal granuloma.

Discussion

Residual lesions following primary coccidioidal

pneumonia may persist for years These lesions may frequently resemble pulmonary tuberculosis, as well as other pulmonary diseases ⁵

A history of pneumonia or "grippe" following exposure in an endemic region in a positive coccidioidin reactor is of aid in the diagnosis of coccidioidal disease However, many infections take place without manifest clinical disease such instances, the differential diagnosis of a pulmonary infiltration may be quite difficult, particularly if the individual reacts to both coccidioidin and tuberculin When this occurs, the diagnosis may be established only by periodic x-ray examinations of the parenchymal lesion 6 Precipitin and complement fixation tests are usually negative in cases of residual nodular infiltrates but may be of diagnostic value when pulmonary cavitation is present

Dissemination usually occurs shortly after the primary infection but sometimes does not appear until years later. The coccidioidin skin test is frequently negative after dissemination due to development of anergy. Diagnosis is established by the recovery of the spherules on biopsy, from sputum, or from draining sinuses. Serologic tests are usually positive.

No treatment is indicated for the residual pulmonary infiltrate, but periodic x-ray examinations should be carried out, since cavitation may occur in the nodular type of coccidioidal lesion

Treatment of coccidioidal granuloma has been disappointing and is conspicuous only by the large number of agents used without effect. Jacobson, however, has reported regression of isolated skin coccidioidomycosis by use of coccidioidal vaccine?

It has been estimated that this disease has occurred in approximately 6,000 members of the armed forces in clinically recognizable form and probably in a far greater number as subclinical infection. Furthermore, disseminated coccidiondomycosis may continue to occur among these individuals for many years. Undoubtedly a percentage of these will be in the nature of widespread dissemination of coccidioidal lesions, and the mortality may be considerable. This is a problem for the medical profession as a whole, since the men who have been exposed to Coccidioides immits infection will be scattered throughout the country.

Conclusion

- 1 Two cases of coccidordomycosis occurring in former army personnel were found after return to civilian activities in New York City
- 2 These cases showed pulmonary infiltrations which were mistaken for tuberculosis
- 3 In cases of pulmonary disease, history taking should include the question of exposure in

the endemic area for coccideoidomy cosss. especially in former army personnel

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FLOWERING GENIUS

The ingenuity of the country doctor is limitless. He can perform nuracles with the most primitive tools. There is the case of a country doctor who was called to see a patient fifteen miles away On arriv ing he found an elderly man suffering from a bladder allment that required his being entheterized Unfor tunately the doctor dld not bring a catheter with him.

He stood looking through the window trying to think of a substitute for he did not relish the idea of making a thirty-mile journey for the missing instrument. He did not pender long for he spotted some long stemmed dandelions growing in a near by field He procured one of the long stems and after soaking it in boric acid used it as a catheter with great succc89.

FIRST PUBLIC HEALTH MENTAL CLINIC OPENFO

The first U.S. Public Health Service demonstra ton mental health clinic has now been opened in Prince Georges County Maryland. The clinic will be operated jointly by the Maryland State Depart-ment of Health and the Public Health Service, with federal funds under the National Mental Health Act. Forty thousand dollars has been appropriated

for the fiscal year 1948.

The clinic will be staffed by Public Health Service personnel. Dr Mabel Ross, child psychiatrist for merly with the Johns Hopkins Hospital will head

the clinic. Herbert Rooney, formerly amistant chief of the Social Service Unit, Boston Regional Office Veterans Administration, and Mrs. Loronza Meister formerly with St. Elizabeth s Hospital, Washington, D.C., will serve as psychiatric social workers. Mrs. Adels Handerson formerly with St. Louis Visiting Nurse Association, as public health A psychologist has not yet been appointed.

Psychiatric service will be offered to all residents of Prince Georges County Maryland which has a population of 140 000

TASTIER FOOD IS PROMISE FOR HEART PATIENTS

The food of heart disease patients won t have to lose its savor because a Brooklyn scientist has applied to water in the human body the same chemical trick that was used to desalt sea water

Dr I J Groenblatt of Beth-El Hospital Brook lyn while serving in the Pacific area, realized that the principle of the ion-exchange deadting emergency kits of planes and lifeboats could be applied to heart cases characterized by dropey and swelling of the joints. He and M E Gilwood of the Permutit Company New York, told the American Chemical Society meeting in Chicago that three tablespoons of a synthetic plastic swallowed after and before meals seem to allow such cardiac cases to eat a more nor mal diet

Saltless tasteless diets largely of nee and starch have had to be the food of such heart cases. With doses of the new plastic more normal food can be eaten as the material removes salt within the intestinal tract before it can get into the blood stream

The ion exchange material used is a synthetic resin ground into tasteless powder grains coated with fatts chemicals and shellac .- Science Vers Letter May 1 1948

Case Reports

AN UNUSUAL CASE OF LEG EDEMA USE OF LATEX RUBBER BANDAGES

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EDEMA formation at times baffles both chinician and physiologist. The contributions of Landis, Drinker, and Warren and Stead have done much to rid edema of its mystery 1-3. Yet, one often encounters cases in which edema, the cause of which is difficult to perceive, plays a prominent role. That here reported affords an interesting problem in diagnosis and therapy of leg edema.

Case Report

M F, a white woman, aged 67, presented herself to the clinic complaining of excessive swelling of both legs. The illness dated back fifteen years when she noted gradual, painless, symmetric swelling of both legs. This swelling was restricted largely to the ankles and calves. Neither the feet nor the thighs were involved. She did not at any time have bouts of fever or glandular swelling. No history of thrombophlebitis, varicosities, cellulitis, or skin lesions of the legs could be elicited. She had never traveled out of the New England states. She had had no surgical operations. Invariably she was told that she had "elephantiasis" or "lymphedema," and that little could be done for her. Elastic bandages (Ace bandages) had been tried but could not be applied effectively on such enormous legs. Over the years the edema gradually increased until it was practically impossible for her to walk. At first she had noted that the edema tended to decrease with bed rest, but lately it had failed to do this

Past History—In her forties she was extremely obese, weighing as much as 350 pounds. Dietary restriction in her early fifties gradually reduced the weight to approximately 250 pounds. She was told five years ago that she had high blood pressure. However, there were no hypertensive symptoms such as headaches or dizzy spells. Signs and symptoms of coronary artery disease or cardiac failure were also notably absent. Other than mild hay fever for the past six years, she had had no illnesses.

She had had two children, and no difficulties had been encountered during labor. The menopause came at age 52 and was without complications

came at age 52 and was without complications

Physical Examination—Height was 5 feet 7
inches, weight 287 pounds, blood pressure 230/120,
pulse 68, respirations 18, temperature 98 8 F A
slight stare was present, but there were no other
suggestive eye findings, nor was the thyroid palpable There was no enlargement of the salivary
nor of the cervical lymph glands The veins were
not distended The heart was regular in rhythm,
and no murmurs were present The aortic second
sound was accentuated The abdomen was soft
and presented no organ edges or masses Both
legs were enormously swollen, especially at the
ankles (Fig 1) Here the circumference was 30
inches The feet were only slightly swollen No
skin lesions were present except that the follicles and

other skin markings were greatly exaggerated. Pitting could be elicited with difficulty, but there was not a typical brawny sensation to the touch. The feet were warm, of good color, and the pulses were apply felt. There were no variousties

easily felt There were no varicosities

Laboratory Findings —Blood count showed hemoglobin 13 5 Gm, white blood cells, 7,500, polymorphonuclear cells 63, lymphocytes 25, monocytes 12

Urine examination showed a specific gravity, 1 018, negative for albumin and glucose, occasional white blood cell and hyaline casts per low power field Blood chemistry tests showed blood proteins 8 Gm., albumin 5 3, globulin 2 7, albumin-globulin ratio 1 9, urea mitrogen 22, creatinine 1 7, cholesterol 192, blood sugar, 118 The Wassermann test was negative



Fig 1 Appearance before therapy was instituted Note that the edema is restricted largely to the ankles Elephantic skin markings are present The patient's weight was 287 pounds

The electrocardiogram was normal except for left axis deviation. A chest x ray showed increase in the transverse diameter of the heart with prepender ance of the left ventricular border, elongation and

tortuosity of the norta.

Course in the Hospital —Complete bed rest with fluid restricted to 1 200 cc dally and salt restriction The legs were elevated 18 inches above heart level On this simple regimen she had a tremendous diure-At the end of six days she had lost 41 pounds in weight with an average loss of 3 250 cc of fluid daily The legs were greatly reduced in size but were still edematous in the dependent portions. During the next six days she lost an additional 6 pounds but it was now evident that the diuresis had ceased this point latex rubber bandages 1/11 inch thick, 3 inches wide and 9 feet long were applied to the legs The tension was adjusted so that most of the constriction was at the ankles. Another diuresis began immediately, and in three days she lost an additional pounds. She was now discharged with instructions to elevate her legs at night and to wear the latex At home she continued bandages during the day to lose weight, so that at the end of one month the weight was 220 pounds a total loss of 58 pounds The circumference of the ankle was now 15 inches Naturally she was overloyed at her prog , this being the first time in ten years that she Another remarkable could walk without difficulty feature was the disappearance of the characteristic resemblance of clephantiasis in the skin Although the skin was loose it was not as redundant as might be expected

Comment.—To what cause may the edehia be at tributed in this case? A cardiac origin is unlikely because of the absence of venous distension and other agns of right heart failure plus the normal dectrocardiogram. The heart was found enlarged at x-ray examination, but this was expected in view of the coexistent hypertension. The normal urms and blood chemistry obviate a renal origin. Venous stans and lymphatic block cannot be considered for at a cosmetic operation two months later the surgeon found no evidence of either condition. Moreover a biopsy of the skin taken at this time showed normal cutaneous and subcutaneous structure. Nutritional edema is ruled out in view of the excellent general nutrition, hemoglobin, and blood proteins. There is nothing in the history, course and other findings to

suggest an infectious origin.

One simple logical cause remains low tissue pressure. It is to be recalled that the patient was a large woman, 5 feet 7 inches tall, and that she was once very obese. A large portion of the adipose tissue was in the legs. With reduction in weight the skin of the legs, especially the ankles, was left very loose. Here, where filtration pressure is normally high, edema began to form. Thus, a vicious cycle was initiated in which edema formation was followed by further stretching of the skin and subcutaneous tissues, naturally making a larger collection of fluid possible, until over the years the woman's legs reached an enormous size. An additional circumstance to support this theory is the fact that when water balance became stationary on hed rest and elevation of the lens a further diurens was obtained by application of the latex rubber bandages. This



Fig 2 Appearance after the application of latex rubber bandages. These are applied over a light cotton stocking to prevent chaling of the skin The winding is begun at the arch of the foot, most tension being applied here and at the ankle to render proper support without constricting bands. The patient found the bandages hot but not uncomfortable

obviously had the effect of increasing tissue pressure-Indeed, one sees edema formation developing in the legs of obese women without an inciting cause other than a low tusue pressure. The use of latex bandages in such patients is suggested

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BILATERAL FEMORAL ARTERIAL ANEURYSMS

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BILATERAL femoral arterial aneurysms are sufficiently rare to warrant this report of another case 1-7

Case Report

N K., an 83-year-old white man, was first seen in the clinic on July 2, 1947 Intermittent claudication in the lower extremities after walking one block had been present for two years. The pain in the left lower extremity extended down the thigh as far as the ankle. The pain in the right lower extremity was limited to the lateral part of the thigh. Swellings in both femoral regions had been noted for five years by the patient.

Physical examination revealed a fairly well-developed and nourished elderly white man. The pupils were equal and regular and reacted promptly to light. Cataracts were present in both eyes. The patient was edentulous. There were no dilated neck veins. The spine revealed mild kyphoscoliosis. The lungs were clear. The heart was not enlarged. There were no murmurs. The second sound at the aortic area was louder than the second sound at the pulmonic area. The blood pressure was 140/80. There was no enlargement of the liver or spleen. A right, indirect, incomplete, reducible inguinal herma was present. There were globular-shaped femoral arternal aneurysms located in Scarpa's triangle on each side (Figs. 1 and 2). The aneurysm of the left side was 2½ by 1½ inches, the right aneurysm measured 1½ by 1½ inches. Bruits were heard over both aneurysms, the left bruit being faint and the right loud. There were no dilated

of the feet
Oscillometric readings were as follows left ankle,
0 25 at 100 mm. of mercury, right ankle, 0, left
calf, 0 5 at 140 mm of mercury, right calf, 0 25 at
100 mm of mercury The electrocardiogram which
was taken on July 7, 1947, was normal, and a roentgenogram of the chest taken on the same day showed
considerable emphysema in both lungs There

veins, nor was there any enlargement of the lower

tibials, and the dorsal pedis vessels were not elicited

No marked trophic changes were noted in the skin

Pulsations in the popliteals, posterior

were a few infiltrations of the left lower lobe. The heart was normal in size and shape. The dorsal spine showed slight scoliosis with a convexity to the left. Roentgenograms of both lower extremities taken on July 16, 1947, showed bilateral extensive calcifications of the posterior tibial, popliteal, and femoral arteries (Fig. 3)

The blood Wassermann was negative The blood cholesterol was 183 mg per cent Urinalysis revealed a specific gravity of 1 020 with no sugar, albu-

min, or microscopic abnormalities

Comment

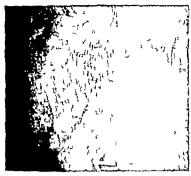
The above case is, to our knowledge, the ninth such recorded in the world literature (Table 1). The ages ranged from twenty-four to eighty-three with an average of fifty-four years. There was no predominant etiology. In two cases the aneurysms were due to arteriosclerosis, in three to syphilis, in three to endarteritis, and in one to a congenital lesion. Allen, Barker, and Hines state that arteriosclerosis is the most common cause of aneurysms of the lower extremities and, less commonly, mycotic arteritis, necrotizing arteritis, and trauma.

The usual sites of aneurysms of the lower extremities are the populeal space and Scarpa's triangle. This is believed to be due to less muscle protection in these regions and to the fact that the frequent bending to which these sites are subjected may tend further to weaken a diseased intima and cause medial degeneration with subsequent aneurysmal formation. Matas stated that aneurysms of the superficial femoral arteries are about ten times more frequent than those of the deep femoral arteries and about four times less common than those of the populteal arteries. Of eight bilateral femoral aneurysms in which the location was reported, ten were in Scarpa's triangle, and six were in the adductor canal.

The most frequent treatment in the cases reported was ligation of the arteries proximal to the aneurysm In the most recent case, however, a bilateral, obliterative endo-aneurysmorrhaphy was performed

TABLE 1 —SALIEVT DATA IN NINE CASES OF BILATERAL FEMORAL ARTERIAL ANEURISMS

	===				
Author	Age	Etiology	Location	Treatment	Complications
Godlee ¹	34	Arterial disease (?) manifest in superfi- cial vessels	Lower portion of ad- ductor canal	Femoral artery li- gated in Scarpa s triangle bilaterally (one year apart)	•
Dreesman ²	55	Lues	Upper portion of ad- ductor canal	(one year apart)	
Lousteau ²	64	Arteriosclerosis	Scarpa s triangle		Gangrene of foot
Franke ⁴	68	Endarteritis	Scarpa's triangle	Left—double ligation Right—extrepation	G
Aspinall ^s	24	Chronic streptoroccal septicemia produc- ing vascular disease	Scarpa s triangle	Proximal ligation of both femoral arter- ies	
Diletti*	63	Lues	Scarpa's triangle	Surgical and anti-	
Pascale (quoted by Diletti')		Lues		140110	
Theron'	38	Congenital localized deficiency of arter- ial walls	Proximal end of ad- ductor canal	Bilateral obliterative endo-sneuryamor- rhaphy	Hemorrhage neces sitating the surgi- cal procedure
Rogers and Rinzler	83	Arteriosclerosis	Scarpa's triangle	ruspuy	out brocedute



Left lower extremity Arrow indicates aneurysm of left femoral artery in region of Scarpa s triangle

The ancuryams in our patient were of approximately five years' duration Symptoms of intermittent claudication were present for two years. The diagnosis was made by the palpation of an expansile pulsating mass bilaterally (Figs 1 and 2) by the sys-



Arrows indicate Lower extremities. location of aneuryams of right and left femoral arteries



Yray of pelvic area to show calcification of femoral vessels at level of Scarpa s triangle.

tolic bruits, and by the presence of calcification in the ancurysmal areas (Fig. 3) We did not believe that arteriography was essential to the diagnosis. Arteriovenous ancurysm could be ruled out by the absence of history of trauma, by the bilateral hature of the lesions by the lack of machinery-like bruits and thrills and by the absence of dilated voins or enlarged lower extremities No surgical intervention was attempted because of the patient s age absence of gross symptoms, absence of progression of the lesions and the presence of a moderately severe degree of calcification of the entire femoral arteries. He was treated conservatively in an effort to maintain the collateral circulation

In view of the frequency of arterioscleratic peripheral vascular disease it is surprising that bilateral femoral aneurysms are not more common.

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WHO NOSE BEST?

Returning to the village of his birth, the proud new doctor decided to call on the old family physician.

I suppose that you intend to specialize" remarked the older man

"Oh yes replied the youth, 'in the diseases of

the nose, for the ears and throat are too complicated to be combined with the ness for study and treatment.

Thereupon the family physician inquired "Which

nostril are you concentrating on?

SOLITARY DIVERTICULUM OF THE CECUM

I CHARLES ZUCKERMAN, M D, and LEON S ALTMAN, M D, Brooklyn, New York

(From the Department of Surgery, Beth-El Hospital)

SOLITARY diverticulum of the cecum with inflammatory changes is an uncommon lesion masmuch as a review of the literature reveals a total of only 48 previously reported cases 1

Most authors are agreed that patients are usually operated on with a preoperative diagnosis of appen-

dicitis, as was true in our case

The majority of diverticuli have been found on the lateral wall of the cecum The lesion is most commonly thought to be either a solitary ulcer of the cecum, such as has been described by Cameron, Barrow, and Wilkie 2-4 These authors report that most simple ulcers usually occur on the medial wall The other lesion most frequently thought of, either preoperatively or at the operating table, and sometimes almost impossible to differentiate, is carcinoma of the cecum.

Most authors are agreed that if the diagnosis can be made, minimal surgery should be done Schnug, in a report on six cases of diverticulities of the cecum, recommends only the most minimal surgery 5

All types of operations have been done, including diverticulectomy, inversion of the diverticulum, closure of the perforation, primary resection of the cecum and/or ascending colon, anastomosis, and The results usually have been good, inasmuch as there have been only two reported deaths

Case Report

K F, a 43-year-old, white widow, was admitted to the surgical service on January 30, 1947, with a history of cramping midepigastric pains with radiation to the right lower quadrant. The patient felt nauseous but had not vomited. The duration of the nauseous but had not vomited The duration of the pain was one day There was no associated diar-The patient gave a history of chronic constipation and had had no bowel movement for two days preceding her entry into the hospital The pain in the right lower quadrant on admission had become

exquisite

Physical examination revealed an acutely ill, wellnourished white woman of good hemic component On abdominal examination, there was marked tenderness over McBurney's point, rebound tenderness, and spasticity of the right lower quadrant There was no abdominal distention, and no masses Rectal examination could be definitely palpated showed no masses, but there was definite tenderness on the right side Vaginal examination was nega-The temperature was 100 F, and the pulse rate 90 per minute The urine was normal, hemoglobin 88 per cent, white blood cells 21,200, differential, 78 per cent polymorphonuclears, 17 per cent lymphocytes, 3 per cent mononuclears, 1 per cent basophils, and 1 per cent eosinophils The preoperative diagnosis was acute appendicitis On the day of admission, an operation was performed. The abdomen was opened through a McBurney incision, and the appendix was found to be slightly injected

On the anterolateral wall of the cecum there was a firm, grayish, ovoid plaque 3 cm by 2 cm, slightly raised above the surrounding cecal wall tion through the thickness of the wall, the plaque gave one the impression of having a rolled mucosal There did not appear margin with a central crater to be any lymphadenopathy present A diagnosis of early ulcerocarcinoma of the cecum was made, and, masmuch as the patient was not prepared for a colonic resection, it was deemed advisable to exteriorize the terminal ileum, cecum, and ascending colon after mobilization in a Mikuliez-like procedure On February 2, 1947, a biopsy of the plaque was taken up to, but not through, the mucosa

The pathologist's report of the specimen was granulation tissue with no evidence of malignancy On February 4, a cecostomy was done for decompres-On February 5, the exteriorized loop was resected with the cautery, leaving a double-barrelled ileocolostomy. The spur was crushed, and on March 21 an extraperitoneal closure of the stoma The patient was discharged on April 2 was done

in good condition
Pathological Examination—The specimen consisted of a segment of terminal ileum, cecum, and proximal portion of ascending colon measuring 17 On the lateral wall of the cecum, an cm in length indurated, grayish plaque, 4 cm in diameter, was On section, the mucosa of the ileum and cecum was edematous but otherwise intact, except for a point 2 cm from the appendicular opening At this point a solitary diverticulum was found measuring 2.5 cm in depth, the neck of which was 0.7 The peridiverticular serosa, as well as the serosa of the adjacent appendix, was covered by a firmly adherent, yellow-white exudate A cecostomy opening was identified at the apex of the ce-cum. The appendix proper showed no gross abnormalities of its wall

Microscopic Description -There was an abrupt loss of muscularis in the region of the neck of the divorticulum The remainder of the diverticular wall was composed of mucosa and muscularis mucosae The subserosal tissues were thickened markedly by an extensive inflammatory evudate composed of a large number of mononuclear leukocytes, lymphocytes, and a moderate number of neutrophils Granulation tissue was evident at the periphery of the inflamed subserosa, and large plaques of partially organized fibrin were seen covering the granu-At two points in the wall of the dilation tissue verticulum there were small ulcerations of the mucosa with abundant underlying acute inflammatory

exudate

Diagnosis -Solitary diverticulities of cecum with extensive organizing pericecal inflammation

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FEVER OF UNDETERMINED ETIOLOGY ASSOCIATED WITH BRONCHOPNEU MONIA CONJUNCTIVITIS STOMATITIS, AND ADENOPATHY (STEVENS IOHNSON SYNDROME)

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(From the Medical Service of the Albany Hospital)

RECENT reports have devoted increasing attention to a clinical complex of undetermined cause characterized by involvement of the eye buced cavity, respiratory tract skin and genitalia. The hierature is well surveyed in two reports an it acordisable number of new cases are added 12. It is noted in these studies that the syndrome may in volve any or all of the systems mentioned above that the determining features of this selection are not known, and that careful pathologic serologic and backgrologic studies have fuiled to churchate the cause.

boll divides the clinical meture into three groups 1 The first promardy affecting the skin with slight involvement of the mucous membrane is the original crythema multiforme exudativium of Helma. second, characterized by severe destructive panophthalmitis associated with extensive oral mucous membrane lessons, and erythematous maculopapu lar rash, was described by Stevens and Johnson ! Into the third group falls most of the new cases reported by Soll Most of these cases occurred in young men who following prodromal symptoms of the upper respiratory tract developed stomatitis with vesicles and pseudomembranes, fever occasionally bronchopneumonia and balantis. Mild conjunctivitis was common, but skin lesions and adenopathy were seen less frequently No urethral involvement or vaccinitis was reported in the women This acute, febrile condition was felt to be self limited Thorough bacteriologic viral and serolone studies revealed no single causative agent al though contammants were noted frequently

The plethorn of torms (Stevens-Johnson syndrome crythema multiforme exudativum cetodet moss crosiva pluriorificals cruptive fover with stomatitis and ophthalman) serves mainly to indicate the capicious involvement of any of a number of systems and gives no insight into the cticlogy or basic nature of the disease. It is suggested however that the term 'Stevens-Johnson syndrome be utilized until the causative agent can be determined since per so it indicates no specific organ complex and yet serves as an identifying term in the writer

of "fevers of undetermined origin

Case Report

A 13-year-old white girl was admitted to the Al bany Hospital on October 18 1947 with the history of onset of a mild upper respiratory infection one week previously. This had persisted and three days prior to entry a moderately productive cough appeared mucoid material but no blood-streaked sputum, was noted. At this time full dozes of sulfastine were begun. The following day her temperature which had only been slightly elevated rose to 100 F orally, this persisted to the time of admission. One day before entry she developed a

rapidly sprending stomatitis associated with a rather severe sore throat. At this time, she was given one injection of 300,000 units of penicillin in oil.

She had no nausen, comiting chills myalgia, retrobuliar pain skin rash or insect bites, no other members of her family presented similar symptoms she had had no contact with rabbits or diseased birds. Her past history family history and social history were of no significance in the present illness.

Physical examination on entry revealed an acutely ill girl with a temperature of 105 F pulse 145, respiration 32 and blood pressure 120/75. There were enlarged discrete moderately firm bilateral anterior circleal lymph nodes No abnormalities were noted in the bones joints or muscles. There was no evidence of rash or other abnormality of the There was periorbital edema and injection with blephoritis and severe conjunctivitis with a pharvns showed a grayish pseudomembrane. The mouth was the site of a diffuse process which extended from the vermilion border of the lips to the pharing it was characterized by vesicle formation which coalesced to form a dirty gravish non-bleeding pseudomembrane over the entire buccul cavity. The chest revealed bilateral posterior medium inspiratory moist rales with some wheezes and rhonchi on expiration The heart was within nor mal limits except for a sinus tachy cardia no unusual findings were noted in the breasts abdomen, or extremities Neurologic examination was negative The pelvic examination was obscured by a profuse menstrual flow

The laboratory findings on admission were as follows red blood cells 3 870,000, hemoglobin 82 per cent white blood cells, 14 900. The differential count revealed 79 per cent polymorphonuclears 12 per cent lymphocytes. I per cent cosinophils and 8 per cent monocytes. Corrected sedimentation rate was 44 mm per hour nonprotein nutrogen was 22 mg per cent. Uring was negative throughout the hospi ial course Blood cultures acrobic and anacrobic were negative, agglutination tests for Brucella abortus B tularense, B typhosus were negative the heterophil antibody fiter was of no positive sig-Cultures and smears of the mouth and pharynx were negative for Corynobacterium diph theria. Sputum cultures revealed a few mondes some contaminating organisms and on one occasion a pneumococcus typo 3 but repented cultures were without significance On one occasion unidentified gram-positive spore-bearing bacili were noted tuberele bacilli were seen Cultures of the conjune tival exudate revealed coagulase-positive Staphylocorcus aureus. Chest roentgenograms revealed by iateral bronchopneumonia.

On entry, in view of hir critical condition, the patient was placed on 60 000 units of pealeillin intramuscularly every four hours and 2 Gm of striptomyem were given followed by 1 Gm, every sixhours Supportive therapy in the form of intraven
ous fluids penicillin eye washes and sedatives was
provided. The temperature and puls (til slowly

ever the fire the days and specific therapy was discontinued on the sixth normal days. The remained
in both for eight days but improved rapidly a for
that and was allowed show the wards. The eye issons disappeared which to results, all but minimal
impring disappeared and the oral before improved
markedly. At the time of her disappeared that
elevanth hospital day her white blood count was
around, and only minimal pigm-nation of the line
and outside more improved remained.

Commen-

Any ber see belonging to the complex grain of Sterms-Johnson spinorers is reputed. It would be remote the mode of mode of the spinor spinorers is reputed of the mode of the composition of the complex with the chinest involvement and that the chinest improvement was one to the grandlin and streptomorn the in the mode of a reasonable in the early of the spinor to specific characters was a chinest to specific the confidence of the second of the spinor to these themselves a spinor to these

raments until a specific esusative agent can be solisted.

Summary

I A lebrile changed complex of conscienable at refit associated with leading of the respirator that the event he hamply notes and the oral mucous memoral has been reported no causative organism manager and.

 It is felt that this represented a variant of the Stevens-Johnson syndrome.

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Fromier is to publish this reservate trained by Dr. Termes Orange processed of measure Change Medical College on whose service the ration was observed.

IRREDUCIBLE HERNIAS IN INFANCY

D. H. MANTELDT M.D., New York City

(From 1 Cultural Surprise Somice, Bellioned Hearth)

TRREDUCIBLE homes in infancy ones in one of the serious problems for which emergin i surpredictive surpredictive surpredictive surpredictive surpredictive in the infancy of the contribution of the contribution of the contribution representation from an infancy of the contribution of the many required there may be included from the case there are the may be included from the contribution of the contribut

Case Reports

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Cree 2—A haby critimes three works of see when a note for no root a smalling in termity from The che'd had been vorting and appeared retful for the theory hours more to admission to the bose isl. Her below induced it e passage of normal stops of more in induced it e passage of normal stops of more in induced it e passage of normal stops of more in induced it e passage of normal stops of more induced the herma in the outsalent department had been only partly successful since a normal of the mass remained meson. Physical examination on admission revealed a three-workhold man criting commonshing amountable in pain. The abdomen was noderately instead of and method here a was meson. The bemis mass about 2 cm in mannered, somewhat indurated, and normalise ble by containing the capture would to see the consistency of at the was mild to chydrated.

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child.

Sammer

Two cases are presented which fall into the category of a rule surpeal emergencies in children. Irreducible bernass which progress to gangere of abdominal visceral especially intestine, present a cangorous threat to hie, as infants withstand intestinal resection van badiv.

640 PARK AVENUE

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NECROLOGY

John C M Brust, M D, of Syracuse, died on May 14 at the age of forty-two Dr Brust was graduated from Syracuse University, College of Medicine, A diplomate of the American Board of Surgery, he served as associate proctologist on the staffs of Syracuse University and Syracuse Memorial Hospitals and as proctologist at the Syracuse Free Dispensary Dr Brust was a member of the American Proctologic Society, the Syracuse Academy of Medicine, and the Alumni Association of Methodist Hospital, as well as the American Medical Association and the New York State and Onondaga County Medical Societies

Reid Gilmore, MD, died on April 28 at his home in Schenectady He was seventy-two Dr Gilmore was graduated from Albany Medical College in 1900 and interned at Ellis Hospital, Schenectady Retired from practice in 1946, Dr Gilmore was a member of the American Medical Association and the New York State and Schenectady County Medical

Lester B Lougee, MD, of Marilla, died recently His age was seventy-five Dr Lougee was graduated from Physio-Medical College in Indiana in He was a member of the American Medical Association, the American School Health Association, and the Eric County and New York State

Medical Societies

Robert E A. Milne, M D, of Le Roy, died on May 4 at the age of forty-eight A native of Canada, Dr Milne was graduated from Toronto University Medical School in 1935 He served as a physician with the rank of major in the 41st Service Group of the United States Army Air Corps in the Mediterranean Theater during World War II Dr Milne was a physician on the staff of Genesee Memorial Hospital, Batavia, and was a member of the American Medical Association and the New York State and Genesee County Medical Societies

Philip E Rossiter, M.D., died on April 30 in He was seventy-one years old Dr Rossiter was a graduate of Long Island College Hospital in He enlisted in the Army in 1916 and was stationed in Hawaii at the outbreak of the war After the war he served in the United States Veterans Bureau, retiring with the rank of major Dr Rossiter entered private practice at Cheming in 1927 and at one time had been a member of the staff of Sea View Hospital, Staten Island, and of Tioga County General Hospital, Waverly He was a member of the American Medical Association and the New York State and Livingston County Medical Societies

Fenton Taylor, M D, sixty, died at his New York City home on May 26 Dr Taylor was graduated from the College of Physicians and Surgeons, Columbia University, in 1913 He joined the British Army in 1916 and won the British Military Cross for gallantry in action with the 1st Leicestershire Brigade in France He later served with the American Red Cross and the American Expeditionary Force in France, attaining the rank of major in the Army Medical Corps An alumnus of Sloane and Presby-terian Hospitals, Dr Taylor had served as head of the Cornell Surgical Division of Bellevue Hospital Recently, he had been a consulting surgeon to the Southampton, Hospital, Southampton, and the New York Hospital, New York City Dr Taylor was a member of the American Medical Association and the New York State and County Medical

John George Vaughan, M D, White Plains, died May 18 at the age of sixty-nine He was graduated from Northwestern University Medical School in 1907 and also studied at the London School of Tropical Medicine In 1909 he was named a medical missionary for the Methodist Church and served for nine years in Nanchang, Kiangsi Province, becoming superintendent of Nanchang Hospital and medical adviser to the city of Nanchang From 1924 to 1929 he was again in China as superintendent of the Wuhu General Hospital on the Yangtze Dr Vaughan was director of the Asso-River ciated Mission Medical Office in New York City He was a fellow of the American Medical Association and a member of the China Medical Association, the American Society of Tropical Medicine, the New York Society of Tropical Medicine, and the New York State and Westchester County Medical Societies

Frank Vero, M D, New York City, died on May 18 He was fifty years old Born in Czechoslovakia, he was graduated from Bratislava in 1922 and took a postgraduate course in dermatology at the University of Vienna. He came to the United States and interned at the United States Public Health Service Marine Hospital, No 70, in 1923 Dr Vero was on the attending staffs of Polyclinic and Presbyterian Hospitals and of the Vanderbilt Chnic of Columbia-Presbyterian Medical Center He was a diplomate of the American Board of Dermatology and Syphilology and a member of the American Medical Association, the American Academy of Dermatology and Syphilology, the Society for Investigative Dermatology, and the New York State and County Medical Societies

APPROVES ALLOWANCES FOR DISABLED VETERAN'S DEPENDENTS

The House Veterans Committee unanimously approved a bill to give \$61,800,000 in special allowances to dependents of 130,700 veterans with disabilities of 60 per cent or more

The bill, if finally approved, would for the first time establish benefits for dependents of disabled men. It would give these

allowances to dependents of totally disabled veterans of World Wars I and II wife, \$30 a month, first child, \$20, next two children, \$15 each, dependent mother or father, \$25 each The allowances would be reduced for lesser disabilities — J A M A, April 17, 1948

ABSTRACT OF MINUTES OF THE COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

A T ITS meeting on April 8 1948 the Council considered the following matters taking action indicated

Secretary a Report

Remission of State Assessments.-Remission of State assessments was voted on account of service with the armed forces for seven members for 1948, 163 for 1947, and one for 1940, also on account of linese for the following members according to county Monroe Ira M Olsan, 1948, Harold L. St. John 1948, John M Swan 1947 Queens Paul Resenthal 1947

Meetings - During the past month your Secretary has taken pleasure in attending meetings of Council Committees and Subcommittees and in handling correspondence On March 10 at Dr Bauer's ro-

quest I represented the Society at the dinner of the National Council on Rehabilitation Arrangements have been completed by Mr Frederick W Miebach Director Information Serv-ice Public Relations Bureau, for a dinner to be tendered in the name of our Society to the Council of the World Medical Association at the Hotel Biltmore on Wednesday April 28 Invitations have been sent to the Trustees the Councillors, officers, and those who attend Council meetings as invited guests, to subscribe for and attend this dinner

Preparations for the Annual Convention have been progressing amouthly Arrangements for registration teaching day section meetings, the Annual Meeting and dinner exhibits—both scientific and technical—and for the meeting of the Woman a Auxiliary are all under way It is anticipated that

the meeting will be well attended As this Annual Meeting is scheduled May 17 to 21

the question arises whother or not you desire to meet the second Thursday in May which would be May 13 only three days before the House convenes. It is presumed that the Council will organize im mediately after the House of Delegates adjourns, probably on May 19 and that you will again meet on Thursday June 10 at the State Society's office at 9 00 л.й.

It was roled not to meet the second Thursday in May in this office, as the Council will organize immediately after the House of Delegates adjourns

May 19

As a supplementary report the Secretary stated he went to Philadelphia the previous Sunday morning to a meeting of the Executive Committee of the Middle Atlantic States Council on Medical Service of the American Medical Association to represent Dr Aranow

Vote of Appreciation to Dr Bauer -Dr Beekman moved that insamuch as this was the last meeting at which Dr Bauer will act as chairman that the Council pass a motion regretting that he is not to continue as chairman at further meetings and of appreciation for what has been done for us during the last year

The Secretary put the motion which was carried by all the members arising and applauding.

Dr Bauer replied as follows

"Gentlemen Dr Beekman kind of caught me naware I had intended as the last thing this morning to express my appreciation to the Council for their unfailing cooperation during the past year

I don't think that any president could carry on the job satisfactorily if he did not have that wholehearted cooperation, and I want to say that I have always had it not only from the Council but from the members who have served on committees, etc., and from the local headquarters staff Dr Anderton and Mr Anderson and others here in the headquar ters office have taken a tromendous load off my shoulders, and I want to say that it has been a very high privilege to preside over you during the past year I have enjoyed it, although I must confess that I am not shedding any tears that it is about over, because it has been rather a long year As you know I had four months more than I should have had because of the untimely death of Dr Hale.

All I can any is that I appreciate very much having been associated with you. You will probably have to tolerate me around for another year as a member of the Council, but I can sit down there with you then Again, I want to thank you for your very patient consideration."

Communications -Letter from Dr J David Hammond, secretary of the Medical Society of the County of Cayuga March 25 1948 regarding the desirability of taking free chest x-rays for anybody

at Auburn City Hospital

After discussion, it was voted that the Secretary reply stating that the State Society is of the opinion that this is a local matter which the County Society ought to determine and that he invite their attention to the fact that the proposi tion probably is intended to pertain to tubercu-losis only which is in line with the State drive toward its eradication.

Letter, March 25 1048 with resolution from Dr B Wallace Hamilton, secretary Medical Society of the County of New York, supporting the Association of the Bar of the City of New York in the efforts to have Congress enact the Silverson Plan of old age security or some modification thereof was read

for information.

A letter of April 2, 1948 from Dr DeWitt Stetten secretary of the United Medical Service, Inc., was read by Dr Anderton This letter expressed disapproval of the action of the A.M A. in discarding the Blue Cross coverage in favor of commercial insurance

After discussion at was voted to refer this letter to our A.M.A. delegates without matructions.

Letter March 19 1948, from Mr Royal W Ryan, executive vice-president, New York Convention and Visitors Bureau Inc. inviting the American Medical Association to hold their interim meeting in New York City in 1949 was considered. As a result, Dr B Wallace Hamilton secretary of the Medical Society of the County of New York, on March 15

1048 ment the following letter

Dear Dootor Anderton
The Comita Minora of the Medical Society of the
County of New York beg to attend a warm and cordila
Invitation to the American Medical Association to hold the
Interim Section of the American Medical Association in
New York City in December 1940.
Our organization will be homored and deeply grateful to
much pypositate the courtesy of your extending this official
invitation.
On behalf of the County Miles.

On behalf of the Comitia Minora, I beg to remain, etc. It was roted that the Council invite the American

Medical Association to hold its interim session in 1949 in New York City

A letter under date of April 2, 1948, from Dr L Dollinow, president, House Staff Council, A.I MS, Psychiatric Division, Bellevue Hospital, New York City, re National Physicians Committee was read and voted to be placed on file

A letter under date of April 2, 1948, from Dr Goodlatte B Gilmore, secretary, Bronx County

Medical Society, was read by the Secretary

We have a list of approximately a dozen men who according to our records, entered military service in 1942 and 1943. Although it could be reasonably assumed that these physicians have been discharged they have never communicated with our offices, and letters forwarded to them at their most recent mailing addresses have been returned.

In accordance with the regulations of the State Society we have had their dues remitted through the year 1947 However, before requesting remission of their 1948 dues, we would like to know if the State Medical Society has placed any limitation on the period for the remission of dues when there is no information available on the doctor

Will you kindly let me know at your very earliest convenience whether we should request the remission of their 1948 assessments or whether we should resign them from membership as of December 31, 1947

Letter under date of March 26, 1948, from Dr Ivan N Peterson, secretary, Medical Society of the County of Tioga, was read by Dr Anderton

Before this county society requests remission of assess ments for this physician I would like your opinion in the

matter

Dr Knight has disposed of his real estate in this county and removed permanently from here from what information I can gather He has told some friends he expects to stay permanently in the Army

Under these expure teneral with no resignation from

Under these circumstances and with no resignation from the society by the physician can we drop him from mem-bership or should we continue to carry him as a member in

After discussion, it was voted that the county societies, in both cases, be advised that they may drop these men without prejudice to their right to be reinstated

Letters from Mr Abraham Orlofsky, dated March 9, 1948, and April 5, 1948, to President Bauer advocating the establishment of a permanent regulatory hospital commission in New York

It was voted to refer these letters to the Committee on Economics

Letter from Dr Bauer, dated April 1, 1948, to Dr Jacob L Lochner, Jr, secretary, New York State Board of Medical Examiners, as follows

Dear Doctor Lochner

The officers and other members of the Council of the Medical Society of the State of New York are anxious to know the present situation in regard to issuing hoeness to practice medicine to graduates of the Middlesex (Massachusetts) Medical School Are there, or are there contemplated, any new developments about hierarchical states of the Middlesex (Massachusetts) Medical School Are there, or are there contemplated, any new developments about hierarchical states. or is the situation closed?

Dr Lochner replied to Dr Bauer under date of April 2, 1948

Dear Dr Bauer
This will acknowledge receipt of your letter of April 1, in which you inquire about the present situation in regard to medical licensure for graduates of Middlesex Medical

School
Please be advised that there are at present approximately thirty-five graduates of Middlesex Medical School planning to petition the Board of Regents for permission to take the New York State Medical licensing examination. One of these cases is on the calendar for the meeting of the Regents Committee on Licenses which will be held in New York City on April 8. The Special Committee set up by the Department to pass on applications from graduates of unapproved medical schools has rejected the applications of this entire group I have advised the Department and the Regents Committee on Licensure previously that it is

my opinion that these boys have only had three years of medical study since the School was closed before they re-ceived their diplomas If there is any further information you desire please let

me know

After discussion, it was voted that the Council protest to the Board of Regents and to the Commissioner of Education about licensing men with unfinished training, and admitting to practice foreign graduates without taking the State exammations

Treasurer's Report was accepted

Report of Executive Officer

Dr Hannon, chairman, reported "The Legislature adjourned Saturday, March 13 The Governor has until midnight of April 12 to complete the thirty-day bills This session of the Legislature was one of the shortest on record It had the greatest number of bills, however, that had ever been introduced. There were over 5,500. There were over 1,100 bills passed by both houses that went The Governor had considered all to the Governor but 200 of those bills up to yesterday when I left Albany

"The four bills that pertain to the State university and the control of future colleges, etc., have The bill that was been signed by the Governor introduced during the last session of the Legislature in regard to discrimination in education has also been signed by the Governor There are only two been signed by the Governor bills in the hands of the Governor at the present time that have not been acted on, which we have followed. One pertains to the medical commission, to the boxing commission or athletic commission which we favored, the other is a bill pertaining to tuberculosis, upon which we had not taken action The bill that permitted the telephoning of prescriptions, which I was instructed through the action of the Council last month to put in an objection upon, has been vetoed by the Governor"

Activities of Committees

Constitution and Bylaws —Dr Reuling, chairman, reported that Amendments to the Constitution and Bylaws of the Medical Society of the County of Orange, under date of March 29, were forwarded to the Secretary who has referred them to the Com-mittee and the Counsel of the Society He stated there was nothing in them to conflict with the Constitution and Bylaws of the State Society and that the Committee recommended approval

The Council voted approval

Malpractice Insurance and Defense Board.—Dr Anderton reported that "Before the last meeting there was distributed to members of the Council a report of the Subcommittee on Malpractice Insurance and Defense Board regarding the study that has been made about the advisability or the madvisability of having an insurance company under the auspices of the Medical Society of the State of New York to carry our malpractice defense and insurance"

After discussion, it was voted that this report be referred to the House of Delegates with the statement that this study appears to have been made by two insurance representatives, one from the Society and one from outside, and that on the basis of the report it would seem madvisable for the Society to undertake the formation of its own insurance company at the present time, that, however, this is only one opinion, and before any intelligent decision can be reached the matter

[Continued on page 1412]



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[Continued from page 1410]

should be further studied and opinions from other groups obtained

Dr Albert F R Andresen requested that a copy of this action and of the report be sent promptly to the Reference Committee of the House of Delegates

Dr Anderton read the following letter from Dr Thomas M D'Angelo, chairman of the Malpractice Insurance and Defense Board, under date of March 31, 1948

Dear Doctor Anderton
The House of Delegates which met in New York City in
1946 ordered an annual audit of the Group Plan of Malpracrice Insurance and Defense by certified public accountants and that the nudit be sent to the component county socieies not less than thirty days prior to the meeting of the

House of Delegates.

At Buffalo in 1947 the House of Delegates approved the report of the Reference Committee on Report of Malpractice Insurance and Defense Board which, in part reads as

RESOLVED, that upon direction of this House or the Council our audit be made by an insurance actuary or

actuaries.

No provision was made in this resolution for the date or disposition of the audit (see page 2216 New York State Journal of Medicine October 15 1947)

The records of the Group Plan for the period ending December 31 1947 have now been completed and are ready for audit Will you please advise whether it is desired to have the audit made by the accountants of the Society or by an insurance actuary in either case whether it is desired that this Board arrange for the audit? If the arrangements are made by your office, it is requested that the accountants or actuaries be instructed to carry out the audit under the direction of this Board so as to carry out the audit under the direction of this Board so as to carry out the intent of the Society and avoid a situation such as occurred last year. In this connection it is pointed out that a complete check of the closed youthers up to the end of 1946 was made last year, and it should not be necessary to incur the expense of repeating that part of the audit

After discussion, it was toted that this be referred to the Board of Trustees with a statement that due to an oversight no arrangements have been made for the audit of the Malpractice Insurance and Defense accounts for the past year, that the results of that audit are supposed to be sent to the county societies thirty days prior to the annual meeting, that \$1,000 appears in the budget for this audit, and that would appear to be the approximate cost, that the Council requests the Board of Trustees to designate the auditor and arrange for this audit so the results can be known as soon before the Annual Meeting as possible

Planning Committee for Medical Policies —Dr Kenney, chairman, submitted summary of the activities of the Committee for the information of the Council. Details of these activities will be presented in the Committee's Annual Report

Public Health and Education -Dr Mitchell,

chairman, reported as follows

"March 24, 1948 -In New York City attended the meeting of the Planning Committee for Medical Policies

"April 6, 1948 —In New York City attended a meeting of the Council Committee on Public Health and Education with the Subcommittee on Child Welfare and representatives of the State Department of Health This conference was held at the request of the State Department of Health to discuss the compensation of physicians who are to participate in a pediatric consultation service and also a fee schedule for laboratory services plan under which they are operating was approved, subject to possible future changes based upon suggestions from us

"April 7, 1948 -In New York City to attend a meeting of the Subcommittee on Cults of the Council Committee on Legislation

"April 8, 1948 -In New York City there will be

a meeting of the Council Committee on Public Health and Education and the Subcommittee on Cancer with representatives of the State Department of Health

Postgraduate Education -Postgraduate instruction has been completed in the following counties Cayuga, Fulton, Onondaga, Richmond, Schenectady and Tompkins

Postgraduate instruction is being given in the following counties Clinton, Jefferson, Madison, Nassau, Oneida, Ontario, Oswego, Rockland, St Clinton, Jefferson, Madison, Lawrence, Saratoga, Sullivan, Tioga, and Ulster

A Regional Teaching Day consisting of five lectures on miscellaneous subjects has been arranged for the Genesce County Medical Society meeting will be held in Rochester on April 21, 1948 The memberships of the following county medical societies will be invited to attend this session Genesee, Orleans, Wyoming, and Livingston

A symposium on medical rehabilitation of children suffering from cerebral palsy and polio has been arranged for the Nassau County Medical Society and will be held on May 25, 1948

A Teaching Day on Nontuberculous Pulmonary Disease is being arranged for the Queens County Medical Society to be held on May 14, 1948, in Jamaica and Forest Hills

Public Relations -Dr Winslow, chairman, pre-

sented the following report

"The Public Relations Bureau has issued 20,000 Years of Service, the commemorative booklet honoring those physicians in New York State who have practiced medicine fifty years or more. To date, booklets have been mailed to the following the fifty-year men, members of the Council, House of Delegates of the State Medical Society, County Society officers, district branch officers, legislative chairmen, presidents and secretaries of all other state societies, the editors of dailies in New York State, and exchange medical journals The total mailing numbers approximately 1,100 Requests have come in for more copies from the fifty-year doctors with letters of appreciation for the booklet

"Bulletin 6 was mailed to State officers, county presidents, and county legislative chairmen of the Woman's Auxiliary This bulletin congratulated the Woman's Auxiliary for the work which it did to defeat the chiropractic bill

"A News Letter was mailed March 26, congratulating those who assisted in legislation this year, particularly the Woman's Auxiliary who aided in defeating the chiropractic bill Reprints of the Reader's ing the chiropractic bill Reprints of the Reader's Digest article, "Our Most Dangerous Lobby—II" were enclosed and orders are being filled for these reprints A JOURNAL reprint of an editorial on District Branches was also included with the News Letter

"A newspaper release entitled "The Six New York State Non-Profit Voluntary Medical Care Plans" was sent to all the weeklies and dailies in the State This release was based on an announcement made by Dr Carlton E Wertz, chairman of the Committee on Economics

"The following postgraduate sessions held under the auspices of the Committee on Public Health and Education were covered by releases to the press Cayuga, Clinton, Fulton, Jefferson, Madison, Nassau, Onondaga, Ontario, Richmond, St. Lawrence, and Tomplans

"Orders for Check and Double Check are still The pamphlet was coming in from other states used by the Investors League at a hearing in Washington last month Mr Anderson conferred with

[Continued on page 1414]

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Mr William Jackman, executive manager of the Investors League, with relation to cooperating with them in defeating legislation for socialized medicine

"Mr Anderson and Mr Miebach attended a meeting of the New York Tuberculosis and Health Association, March 9 Mr Miebach spent a week m Westchester County studying the public relations of the Society He attended the Eighth Annual Health Education Conference of the New York Academy of Medicine, April 1 and 2

"Mr Walsh addressed the Woman's Auxiliary in Onondaga County and Albany County, speaking on legislation He also attended Mrs Pohlmann's meeting on cooperation in medical public relations "

Publication -Dr Kosmak, chairman, reported that the Publication Committee met on April 7 and discussed a number of routine matters, that the editorial group had held three meetings during the month, that the Committee was worried about the increasing costs of publication, and that although the advertising has diminished the rates have been in-

Liaison with the Veterans Administration —Dr Bauckus, chairman, made the following report

"Our coordinators at present have little contact with administrative forces in the four areas there is a very deliberate attempt to keep coordinators from participation except where absolutely necessary In the New York City area cases which coordinators saw and were responsible for have decreased from 3,000 to 300 a week

"Various changes in VA policy have occurred Refusal to allow surgical cases to be hospitalized except in VA facilities, establishment of neuropsychiatric clinics where neuropsychiatrists are em-

ployed by the hour
"In the Buffalo area cases are no longer author-Patients are requested to go to local clinics Physicians have been approached by local VA branches to take certain cases at specified rates and for specified duration In some instances patients have been refused treatment These changes are not due to lack of funds as has been occasionally claimed Dr Magnuson, National Director of VA, printed facts in the New York County official publication which are important but do not give the real cause of these changes Dr Anderton and I recently met Dr Harding, who had charge of this He talked principally on two things program reduction of medical fees and the lessened need for coordinators, stating they might well be employed

by VA and not by Veterans Medical Service Plan "Although I have not been told, I feel that when our contract expires in August supervision of the plan will be removed I doubt if we will have any coordinating physicians, and I feel that the national The contract comes up fee schedule will be used for renewal sixty days before August 8, and I feel the Council should make a study of this whole matter before the House of Delegates meets Dr Magnuson was supposed to meet a special committee of the A.M.A but has not yet done so I understand he has conferred with Dr Lull and the president, I understand but nothing seems to have been done except to ask that we encourage physicians to join in the work of

VA as part-time or full-time employes
"Derogatory remarks have been made about
physicians in New York State and their part in the
program, which have had the deared effect on the public and which the State Society has done nothing

"We have established this program for the pur-

ans with service-connected disabilities, the Veterans Administration came to us and asked us to do it, and we are spending our money to carry on the program. The public still has the idea that we approve of what is going on. I cannot approve after what has been happening in the last six months I don't know whether we should take the initiative and come out with our disapproval and withdraw This is a question I think you need to consider withdraw, I feel the fee schedule will immediately change and perhaps the entire plan be discarded, or perhaps VA will change its present stand and go along with our desires

"I feel that with this much of a report, it is up to the Council to make careful decisions regarding our future conduct"

Dr Aranow stated that Dr Howard A Rusk had an editorial in the New York Times on February 22, 1948, entitled "Medical Care for Veterans Big Problem for Country" which he thought the Council He read the following excerpts should study

"Periodically twenty-five of the nation's top medical specialists meet in Washington as the National Consultants' Committee to the Administrator of Veterans Affairs to determine policy and discuss problems of veterans' medical care their meeting in October, and again in January, two of the principal items on the agenda were the need for more personnel and the feasibility of

placing a fixed caling on the number of hospital beds that the VA will operate

"Today, the VA operates a total of 103,189 beds, and has 5,649 beds closed because of inability to obtain personnel. Their patient census is 95,652 in their own hospitals and 13,949 in Army Navy, state, and civilian contract hospitals the 109,601 patients (as of January 15, 1948), however, 66 per cent are nonservice-connected, that is, the disabilities for which they are hospitalized have no relationship to their military service
"There are 18,026 veterans awaiting admission

to VA hospitals, of which only 88 are definitely service-connected, and 446 are presumed service-connected on the basis of available evidence. The remaining 17,492 have disabilities that were not

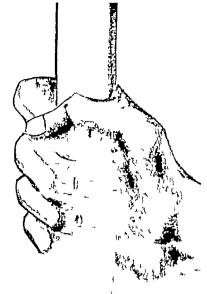
incurred in service

"The hospitalization policy in VA hospitals, as dictated by existing laws, is that veterans with service-connected disabilities shall have admission priority, but that veterans with nonservice-connected disabilities may be admitted if, by their own statement, they are unable to pay for hospital care and if a bed is available in an existing facility

'The VA now has 126 hospitals, and Congress has approved the building of 91 more at a cost of Many of these new hospitals \$1,000,000,000 are necessary to replace existing outdated hospitals situated in areas so geographically remote that it is impossible to staff them adequately Others are necessary as replacements for the temporary wartime Army and Navy hospitals that the VA has taken over Biggest factor in the building program however, is the policy of furnishing free medical care to nonservice-connected

"It is the opinion of this group of consultants to the Administrator of Veterans Affairs that a definite ceiling should be put on the number of beds to be provided in VA hospitals and that such a ceiling in the opinion of this group should not exceed the 140,000 beds already authorized by Congress

break the grip of an asthmatic attack



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"They further warned 'It will be practically impossible to find adequately trained personnel to operate this number of beds, when at the present time, 5,649 beds are already closed solely because of lack of personnel Second, to attempt to go beyond this ceiling would further deplete the number of trained individuals available to meet civilian needs?

"Dr Magnuson was even more conservative and said that 120,000 beds represented, in his opinion, the maximum number of permanent beds the VA could operate and give top-flight medical care without disturbing the balance between VA and civilian hospitalization"

After discussion, it was voted that these matters be brought to the attention of the House of Delegates by Dr Aranow and Dr Bauckus

It was voted that the Society call to the attention of the Veterans Administration immediately that they are not satisfied with the way the contract is working, and that there are violations of it

Woman's Auxiliary -Dr Beckman, chairman, reported as follows

"Lreceived a letter on March 11, 1948, from Mrs Edgar M Neptune, the President-elect of the Woman's Auviliary

'It is the recommendation of our District Councillors that we hold district meetings of the Woman's Auxiliary concurrently with the district meeting of the Men's Society These meetings would be planned so that they could in no way conflict with the program already set up by the district Medical Society

'The procedure as suggested above would eliminate much travel yet, at the same time, would enable the President to meet all of the counties, by districts, rather than by visits to the individual

counties

'I am writing you, the Chairman of our Advisory Council, to request your approval of such a program for the ensuing year I realize that although I will be working with next year's Advisory Committee I feel that we must make some plans now—tentatively at least—for our new year I am, therefore, very anxious to have vour reply sanctioning this proposed program of contacting the counties'

"I communicated with Dr Van Etten and Dr Dickon, the other members of the Advisory Council, and they were most enthusiastic, so if there is no objection from the Council of the State Society, I will inform Mrs. Neptune we think it a wise plan

After discussion, it was voted that Dr Beekman be requested to inform Mrs Neptune that, to avoid confusion, it would be well for her to coordinate these plans for District Branch meetings through Dr Hannon

Workmen's Compensation -Dr Kenney, chair-

man, presented the following report

"On March 16, 1948, Mr Mac F Cahal, executive secretary of the American College of Radiology, came to this office to discuss legal action in connection with the dismissal of a radiologist from a hospital in New York State No commitments were made

"On March 18, your Director appeared before the Medical Appeals Unit of the Industrial Council in support of the action taken by the Jefferson County Medical Society, Workmen's Compensation Committee, in refusing a medical bureau license to a local plant of the New York Air Brake Company in Watertown, New York

were held in Albany for the counties of Albany Montgomery, Rensselaer, Saratoga, Fulton, and Warren

"New London Medical Association -On March 23, Dr Thomas Soltz, secretary of the New London County Medical Association, and Mr Joseph M Rourke, secretary-treasurer of the Connecticut Federation of Labor, came here to discuss possible revisions in the Connecticut workmen's compensation law

"Group Medical Practice -On March 12, Jos A Lane, secretary of the Medical Society of the Country of Monroe wrote Dr W P Anderton, Secretary, asking for an opinion Two Rochester physicians doing largely compensation practice indicated that they would like to have a third physician associated with them as part time radiologist

"The aucstion asked was whether the usual 331/2 per cent allowed under the Workmen's Compensation Law would be approved as payment in an arrangement made by the physicians rather than

with the hospital

"After consultation with Mr Thomas H Clearwater and Dr J Stanley Kenney, and at the suggestion of Dr Anderton, a reply was sent to Dr Lane outlining the provisions of Section 6514 of the Education Law and of 13-d of the Workmen's Com-

pensation Law that apply

"The technicalities of the Education Law and the Workmen's Compensation Law make it difficult for physicians to enter into ethical relationships without violating one or the other of these statutes or without violating the new group partnership laws apparent that laws restricting to workmen's compensation practice alone cannot be effectively enforced, because very few physicians restrict their practice to compensation work. Such laws create situations almost impossible of solution should be a revision and substantive changes in all laws applying to medical practice so as to make them uniform, equitable, and enforceable

"The present statutes applying to rebating and fee splitting in both the Education Law and in the Workmen's Compensation Law are so drawn as to make almost any physician guilty of a technical violation of these laws under normal circumstances

"Treatment Rendered by Podiatrists —It has been brought to our attention that an order was issued by the Department of Labor to the effect that an employer could authorize a podiatrist to render medical care independently and be paid a fee up to This order \$25 by an insurance carrier or employer was published in the Journal of Podiatry and was brought to our attention recently when a podiatrist was referred to this office for an opinion concerning a patient whom he had accepted initially for treatment of a sprained ankle. The insurance carrier refused to pay his bill for services rendered and referred him to this office for an opinion
"Section 13-a of the Workmen's Compensation

'(1) An injured employe may, when Lan states care is required, select to treat him any physician authorized by the chairman to render medical care, as hereinafter provided' Thus no practitioner other than an authorized practitioner of medicine

may be authorized to render medical care

"In the Szold vs Outlet Embroidery decision, Mr Justice Shientag held, 'The new law establishes a system whereby the rendering of medical care under the Compensation Act is restricted to physicians specifically authorized to do such work by the Industrial Commissioner Except in case of emergency, and where a patient is confined in a hospital only an authorized physician may render medical

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LEGAL MEDICINE TO HAVE NATIONAL SOCIETY

A national medicolegal society—the only one of its kind—is being formed under the sponsorship of prominent doctors, scientists and lawyers. It will probably have its first full-scale convention in 1949 An internal body met recently in St. Louis heard papers on current criminomedical problems, and started back.

started basic planning for a permanent organization.

Announced aims include (1) continuing study of scientific knowledge and technics as they imping upon legal procedures and controverses (2) education of decirations and other secuntific men in legal doctrine, (3) improvement of the professional qualifications of scientists engaged in medicologial work and (4) improvement and standardization of technics through meetings, publications reports, and other projects.

Projects.

Trune mover in the new organization is Dr R. B II. Gradwohl, director of the Gradwoll Laboratories and of the St. Louis police departments research bureau. Among those who read papers at the St. Louis meeting were Dr Lemoyne Snyder inventor of the 'intoximeter' and medical adviser of the Michigan State Police Dr Alexander S Wiener codiscoverer of the Rh factor and scrologist of the medical examiners office New York. Dr Leo Alexander Boston chief psychiatrist at the Nuren berg war-crime trails, and Commander W R Grswold, MLO representing the Surgeon General of the Navy—Medical Economics May 1848

FORMS NEEDED BEFORE BABY CAN BE BORN

J M Mitchell County Clerk of Fife, said in Edinburg that the confusion caused by the Govern ment's assumption of power formerly held by local authorities was such that when the National Health Sorvice came into being in July, babies could not, in law be born without the filling up of special forms

A mother would have to depend on the executive council for the doctor, on the local health authority for the nurse, and on the hespital board for the specialist and a bed No one would be in a position, as at present to provide her with all three services at one time

Pending the arrival of the baby, the mother must complete a multiplicity of forms. Before the into was dry on the forms nature would have intervened and, in defiance of the law the baby would have been born by natural process.

born by natural processes.

Then Mr Mitchell added "it will be an interesting matter for a debate in law whether the Government department, the mother or the baby was at faul."

Needless duplication of personnel and waste of time and material caused by Government forms covering almost every phase of the wore such that local government staff increases could not be avoided.

-from the London Times J.A.M A , April 17 1948

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care and obtain payment therefore Under the amendment, if an employer furnishes medical treatment to an employe he must provide an authorized physician, since no other may legally treat compensation patients To hold otherwise would be to circumvent and render nugatory the salutary amendments which those interested in the proper administration of this beneficient statute have striven so long to obtain Whether the doctor is chosen by the employe or under certain enumerated conditions by the employer, one thing is implicit in the amended statute, the physician must be one authorized to render medical treatment in Workmen's Compensation cases

"Thus it is apparent that, since podiatrists are not directly mentioned in the law, they may not treat compensation claimants independently Under the compensation claimants independently provisions of Section 13-b, no provisions are made for the authorization of other than licensed physi-There are certain specific exceptions which are that emergency medical care may be rendered by any physician licensed to practice medicine without authorization Further, a licensed physician who is a member of a constituted medical staff of any hospital may render medical care under this chapter while an injured employe remains a patient in such hospital and under the personal supervision of an authorized physician medical care may be rendered by a registered nurse, registered physiotherapist, or other person trained in laboratory or diagnostic technics within the scope of such person's specialized training and qualifications This supervision shall be evidenced by signed records Reports shall be made by such physician to the chairman on such forms and at such times as the chairman may re-Even here there is no mention of a podiatrist, although it might be conceded that under certain conditions the section might be stretched to include the services of a podiatrist, if the authorized physician in charge of the patient deems that his special skill might be necessary. This section also applies to dentists and requires authorization before

they can institute dental care
"We are of the opinion that any rule or regulation authorizing the treatment of compensation patients by podiatrists is contrary to law Additional arguments might be adduced to show that the law might be circumvented by permitting such treatment independently by a podiatrist, since he is not obliged to report cases and is also not liable to the regulatory provisions of the Workmen's Compensation Law According to a communication from Mr Henry D Sayer of the Compensation Insurance Rating Board, Miss Donlon has recently expressed an opinion to the effect that a podiatrist may not treat within the purview of the Workmen's Compensation Law-except on prescription or at the direction of an authorized physician within the scope

of the podiatrist's qualifications "

Dr Kenney further reported he had attended a meeting of the Advisory Council at Miss Donlon's office on April 6, 1948 A new office for the adminisoffice on April 6, 1948 A new office for the administration of Workmen's Compensation was opened in

Binghamton on March 1
Legislation—None of the bills presented by the Workmen's Compensation Committee reached the We had only a few, and none were contro-We felt our bills were introduced mainly to stress our points, hoping that next year, with perhaps a new administration setup in New York, we will progress further We did not lose anything, and we followed the mandates of the House of Delegates

Dr Kenney presented the following standard form which was discussed at the Advisory Council meet-

The point raised was that some other word should be substituted for the word "waiver"

WODKMENC	COMPENSATION	DOIDD
MOURTMEN 9	COMPENDATION	ひひれたひ
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Notice of Waiver by Employee of Right to Choose His Own Physician

If the injured Employee freely waives his right to choose his own physician and prefers the Employer to designate a physician the Employee should sign this waiver

THIS WAIVER MAY NOT BE SIGNED BEFORE INJURY AND MAY BE REVOKED BY THE EMPLOYEE AT WILL

If the Employees disability is within the provisions of the Workmen's Compensation Law, the Employer is required to pay the cost of necessary medical care and the injured Employee is entitled to be treated by the physician of his free choice' provided the physician has been authorized by the Chairman to render medical care under the Workmen's Compensation Law

WCB Case No	Carrier a Case No	Date of Accident
	1.	
То		
(Employer)		
(Address)	 	
The vide	undersigned requests b	ns Employer to pro-

care for the injury which occurred on (date) with Sec. 13 a of the Workmen's Compensation Law which permits an injured Employee to waive the right freely to select his own physi-

The undersigned Employee may subsequently engage the services of any authorized physician of his own free choice for continued treatment or further medical care as required, without notice of his election to do so

Witness	Employees Signature
Date	Home Address
C-3 1 (Draft March 9 194)	8)

After discussion, it was voted that Dr Kenney and Dr Kaliski be given authority to make recommendations to Miss Donlon relative to the wording of this form

It was voted that Dr Kenney be given tentative approval by the Council to provide an exhibit and other means of cooperation at a convention of a national workmen's compensation organization of which Miss Donlon is president. The esti-mated cost is to be submitted later for approval of the Council and the Board of Trustees

Minimum Fee Schedule - Dr Anderton stated that the new fee schedule is completed It has been handed to Miss Donlon by her Advisory It is in the process of compilation Committee will be published in pamphlet form as formerly accomplish that there will have to be about a month for bids for printing The printing will have to be very carefully reviewed on account of possible errors Any errors regarding fees would be very serious is expected that the new fee schedule will be promulgated by September 1, or perhaps earlier

New Business .- World Health Organization -Dr Aranow reported that a House of Representatives Committee had tabled the resolution that America join the World Health Organization, and he felt that the State Society should take some action to find out the reason why this was done

After discussion, it was voted that Dr Bauer be authorized to draft a letter recommending a reversal of the Committee's stand on this subject.

National Emergency Medical Service Meeting in Chicago —Dr Redway, who had attended the meeting, made his report, a copy of which has been transcribed and is in the file



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WOMAN'S AUXILIARY

TO THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

Auxiliary Holds Annual Meeting

THE twelfth annual meeting of the House of Delegates of the Woman's Auxiliary to the Medical Society of the State of New York convened in New York City at the Hotel Pennsylvania on Monday, May 17, 1948, with Mrs Harry F Pohlmann presiding Attending were 63 members of the Executive Board, 100 delegates, 14 alternates, and 55 guests

Guests of honor present included Mrs Eustace A Allen, Atlanta, Georgia, president of the National Auxiliary Mrs Luther H Kice, New York, national president-elect, Mrs Rufus M Bierly and Mrs Paul C Craig, president and president-elect of the Pennsylvania State Auxiliary, Mrs Drury Hinton and Mrs Edgar S Buyers, Pennsylvania, Mrs E Benjamin Gillette, president of the Ohio State Auxiliary, and Mrs Robert B Walker of the New Jersey State Auxiliary

Mrs William Lavelle, councilor for the Second District and a past president of the Queens County Auxiliary, was elected president-elect and will take office as State Auxiliary president in May, 1949 Mrs Edgar M Neptune, Syracuse, was inducted

into office as State Auxiliary president for the coming year

Serving with Mrs Neptune are Mrs Herman W Galster, Scotia, first vice-president, Mrs Morris H Newton, Little Falls, second vice-president, Mrs Thomas M. D'Angelo, Flushing, recording secretary, Mrs Robert H Rowner, Syracuse, corresponding secretary, and Mrs Hugh G Henry, Germantown, treasurer Directors are for three years Mrs Pohlmann, Middletown, and Mrs Bradford F Golly, Rome, for two years Mrs Alfred L Madden, Albany, and Mrs Byron D St John, Port Washington, and for one year Mrs Edwin A Griffin, Brooklyn, and Mrs Charles R Seymour, Binghamton

District Councilors include District 1—Mrs J Emerson Noll, Port Jervis, District 2—Mrs Clifton Louis Dance, Brooklyn, District 3—Mrs Albert Vander Veer, Albany District 4—Mrs E M Stanton, Duanesburg, District 5—Mrs John L H Mason, Pulaski, District 6—Mrs M M Monser-

rate, Binghamton, District 7—Mrs Harry I Norton, Rochester, and District 8—Mrs Arthur L. Bennett, Buffalo

Committee chairmen are Mrs J D Hallinan, Richmond Hill, archives, Mrs Clarence J Durshordwe, Buffalo, convention, Mrs Harold B Johnson, Buffalo, finance, Mrs Arthur F Holding, Albany, historian, Mrs Robert Harris, Sodus, Hygeia, Mrs John Horner, Albany, legislation, Mrs Charles I Miller, Rochester, national bulletin, Mrs Morris H Newton, Little Falls, organization, Mrs Francis R Irving, Syracuse, parliamentarian, Mrs George P Bergmann, Greenport, Physicians' Home, Mrs Lee R. Sanborn, Angola, Distaff

Also Mrs Walter A Schmitz, Middletown, press and publicity, Mrs John J Quinlan, Troy, printing and supplies, Mrs M G Sheldon, Olean, program, Mrs William Bartels, Garden City, public relations, and Mrs Edwin A Griffin, Brook-

lyn, revisions

Special chairmen are Mrs John J Bucttner, Syracuse, board meetings, and Mrs Thomas E

Bullard, Schuylerville, clippings

During the past year, Chenango, Clinton, Ontario, Schoharie, Seneca, and Sullivan Counties have organized auxiliaries, and, with Westchester soon to be organized, there will be a total of 45 Membership at present totals 3,291, and Westchester will add

to that figure appreciably

At the annual meeting, Mrs Neptune, incoming president, outlined plans for the establishment of various study groups to be conducted by the local auxiliaries, and Mrs Pohlmann, retiring president reviewed the State Auxiliary's activities during the past year, stressing the work in nurse recruitment the distribution of medical literature to schools and libraries, and the educational program in behalf of voluntary medical care programs

Mrs Clifton L Dance, convention chairman, and Mrs William J Lavelle, co-chairman, aided by their committees, made all arrangements for the 1948 convention meetings and social functions, and are to be congratulated on the outstanding success of their

efforts

NEW YORKERS WILL LOSE \$40,000,000 FROM COMMON COLD IN 1948

Statisticians of the New York City Health Department estimated recently that New Yorkers will suffer collectively, 205,000 years of distress from colds in 1948, and at the same time lose \$30,000,000 in earnings because of absence from work

Adding a conservative \$10,000,000 for doctor's bills and medicine, the health department estimates a total of \$40,000,000 as the total loss to the 3,450,-

)

000 employed persons in the city, with colds credited with one third of an estimated average absenteeism of one day per person

The statisticians, as reported by the New Yor. Times, arrived at the figures by allowing each of th 7,500,000 New Yorkers two colds this year, and fiv days for each cold. The average daily wage wa estimated at nine dollars.

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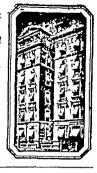
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